with such activities as preparing meals, personal care, monitoring medications or other aspects of daily health care, managing money. (About 10 percent of elder residents need all these types of assistance by one set of estimates or the other.) About one-quarter need help in arranging social and recreational activities.

The impression that emerges from Tables 4-5 and 4-6 is that many elders in public housing need relatively low-level service assistance. That is, they need help overcoming social isolation, help with transportation and shopping, and some help in caring for units. A smaller percentage needs assistance with emotional, medical, or financial problems, or need more intense help in activities or daily living (e.g.,personal care, preparing meals).

Unless specialized professional services are required, of course, it is ideal for family and friends to provide assistance. It will be remembered that PHA administrators cited difficulty in obtaining cooperation from tenants' families as a very common problem. When an elder resident begins to experience problems, managers seem to look first to family to help out. Evidently, there are many cases when no such help is forthcoming. Then the resident and the manager must fall back on some other resource--on peer assistance and informal help for occasional low-level problems, on professional service providers for more severe difficulties. If appropriate resources are not available, a premature move to a nursing home may result.

4.5 Services Available to Elder Residents

Both managers and service providers were given a list of services that might be provided and were asked choose between four

response categories: (1) service is routinely provided by the PHA; (2) service is routinely provided by some other agency; (3) service is not provided on-site but is available off-site; and (4) service is not readily available. "Routinely" was defined as weekly for most services, but as at least four times per year for health clinic and screening services.) The responses are shown in Table 4-7 (Managers) and Table 4-8 (Service Providers).

In Table 4-7, managers report that a number of services are available in a majority of the sample developments. The first two columns represent services delivered on-site, either by the PHA or by another agency. They do not represent the percentage of elders who receive these services, of course--simply the percentage of developments in which they are delivered to at least one person. Where they are available to one, they may be available to others. But for many reasons, many potential recipients also may not receive them--inadequate outreach, inadequate resources to meet need, elders who do not take initiative to contact providers, elders who cannot afford fees that may be charged, etc.

The services most widely available by this measure are meals-on-wheels, homemakers or home health aides, and visiting nurses. About 79 percent of the managers said such services were delivered routinely in their developments. Transportation (76.3 percent), social/recreation programs (57.9 percent), case manager or case coordinator services (55.3 percent), and counseling (52.6 percent) were also present in over half the developments. Congregate meals and health clinics which offer general medical attention were less common, but still present in over one-third of the sample developments. On-site peer assistance programs and alcoholism programs

Table 4-7
(Managers' Responses)
Services Routinely Delivered to Elder Residents of Public Housing

Question: Which of the following services or resources are routinely delivered on-site? ("Routinely" means at least weekly or more frequently for meals, transportation, recreation, homemaker/home healh aide/home nursing services, and counseling/service coordination services; at least four times per year for health clinic/screening services.)(CIRCLE ONE RESPONSE FOR EACH ITEM.)

	Percent of PHAs giving each response...			
	Yes operated by PHA	Yes operated by another agency	No, but available off-site	No, not readily available
Case manager/service coordinator to diagnose needs & help organize/allocate services	34.2%	21.1%	31.6%	13.1%
Congregate meals	5.3	31.6	18.4	44.7
Meals-on-wheels	7.9	71.1	7.9	13.2
Social/recreation program	26.3	31.6	23.7	18.4
Transportation program	10.5	65.8	10.5	13.2
Health clinic (general medical care)	0	39.5	44.7	15.8
Health screening (e.g., vision, blood pressure)	0	63.2	34.2	2.6
Homemaker/Home Health Aide	10.5	68.4	13.2	7.9
Public health/ Visiting Nurse	0	78.9	13.2	7.9
Social and personal counseling	34.2	18.4	36.8	10.5
Peer assistance (formal program)	2.6	7.9	28.9	60.5
Alcoholism treatment	0	15.8	63.2	21.0
Other	5.3	0	0	0

Source: Development-level instrument
N=38

Table 4-8
(Service Providers' Responses)
Services Routinely Delivered to Elder Residents of Public Housing

Question: Which of the following services or resources are routinely delivered on-site? ("Routinely" means at least weekly or more frequently for meals, transportation, recreation, homemaker/home health aide/home nursing services, and counseling/service coordination services; at least four times per year for health clinic/screening services.)(CIRCLE ONE RESPONSE FOR EACH ITEM.)

	Percent of PHAs giving each response...			
	Yes operated by PHA	Yes operated by another agency	No, but available off-site	No, not readily available
Case manager/service coordinator to diagnose needs & help organize/allocate services	70.8%	12.5%	8.3%	8.3%
Congregate meals	20.8	29.2	29.2	20.8
Meals-on-wheels	4.2	83.3	12.5	0
Social/recreation program	62.5	12.5	12.5	12.5
Transportation program	33.3	41.7	20.8	4.2
Health clinic (general medical care)	8.3	37.5	41.7	12.5
Health screening (e.g., vision, blood pressure)	12.5	66.7	20.8	0
Homemaker/Home Health Aide	29.2	70.8	0	0
Public health/ Visiting Nurse	8.3	87.5	4.2	0
Social and personal counseling	54.2	25.0	4.2	16.7
Peer assistance (formal program)	12.5	20.8	20.8	45.9
Alcoholism treatment	0	16.7	58.3	25.0
Other	12.5	8.3	0	-

Source: Development-level instrument
N=24

appear to be relatively uncommon.

There were some differences between responses by managers of elderly developments and managers of family developments. Health screening services were much more likely to be delivered in elderly developments. Seventy-five percent of all elderly and congregate developments reported such services, compared to 30 percent of family developments. Most other differences showed higher service levels at elderly than at family developments, but the amount of difference was less striking.

Table 4-8 shows responses by service providers to the same set of questions. These reports of services delivered are almost uniformly higher than reports by managers. The percentage of developments in which PHA-provided services are available is higher than managers' reports for every service listed. This doubtless reflects some confusion about who provides a service rather than disagreement about whether or not the service is available. Even if the percentages in the first two columns are combined, however, giving a measure of on-site availability apart from sponsorship, the service providers' estimates are still markedly higher than those of managers. For example, service providers say that on-site homemaker/home health aide services are available at 100 percent of the developments in the sample; the comparable figure for managers is 78.9 percent. Likewise, service providers' figures are strikingly higher for case manager or service coordinator services, visiting nurses, counseling, and formal peer assistance programs.

It is impossible to decide which report is most likely to be correct. While managers presumably know more than service providers about on-site activities and PHA-sponsored programs, the ser-

vice providers probably know more about their own programs and who they serve. (Since these service providers might represent any of a variety of programs, we cannot distinguish between responses about their own programs and those about programs operated by some other service agency.) It may be that the services reported by providers are delivered only to a few residents in the developments. In these circumstances, providers might know about them and managers might not. Indeed, managers frequently complain that they do not know what services their residents are getting, and therefore do not know whom to contact in a crisis. Service providers often answer this complaint by talking about confidentiality regulations which make it difficult to share information about clients with representatives of another agency.

Two conclusions seem likely on the basis of these data. First, service providers appear to overestimate the extent of service available to elder residents directly from the PHA. This misperception might lead providers to do less outreach in public housing than they would do otherwise, thinking that their services are not as much needed as they actually are. Secondly, it may also inhibit cooperation among service provider agencies: if one agency does not know that another agency is also active in a development, then an alliance to serve residents better is not likely to occur. If either misunderstanding is present, service providers are more likely to leave service programs to the PHA's initiative, or to serve scattered individuals rather than attempting a more comprehensive approach.

Whatever the cause, these patterns of institutional behavior

are widely reported to be the case. Service agencies are said to be oriented toward serving individuals in public housing much as they serve individuals in scattered private houses or apartments. This approach is often blind to opportunities to provide better care and achieve greater economies of scale by taking advantage of the clustering of elder residents in a housing development. Managers also frequently report that service agencies assume that elders in public housing are taken care of by the PHA, and that the provider agencies therefore ignore this part of their target population. Meanwhile, PHAs lack the funds to provide many services themselves, and often feel that service provider agencies could do a better job in any case. Clearly, both sets of institutions need each other to carry out their own responsibilities well. Yet examples of cooperative programs are all too rare. (However, see Chapter 5 for some illustrative examples of programs of this type.)

4.6 Utilization of Services By Elder Residents

The previous section dealt with percentages of developments in which service of a particular type are delivered to any resident. This section discusses measures of the percentages of elder residents who actually receive certain services. Again, responses are available both from PHA site managers and from representatives of service provider agencies. The question did not distinguish between on-site and off-site services. The answers therefore represent estimates of the percentage of elder residents who make use of a particular kind of service, regardless of who provides it or whether it is provided in the development or not.

The data are shown in Table 4-9. Estimates by managers and

Table 4-9

Percent of Elder Residents Receiving Certain Services

Service	Managers (Mean percent)	Service Providers (Mean percent)
Meals-on-Wheels	9.6	7.0
Congregate meals	14.6	18.6
Social/recreational program	29.9	34.8
Transportation program	24.9	35.0*
Homemaker/home health aide	15.9	18.8
Public Health/Visiting Nurse	15.1	16.3
Health screening/clinic	22.9	22.9
Friendly visitors	14.7	16.4
Counseling/case management	16.7	25.1
Alcoholism treatment	2.0	1.7
Other	0	0
	N=34	N=21

Source: Development-level instrument

* Difference between service providers' estimate and managers' estimate is statistically significant at the .05 level or better.

service providers are relatively similar. Provider estimates again tend to be higher, but the difference is statistically significant only in one instance--that of transportation programs. Social/recreational programs and transportations seem to reach the highest percentage of elder residents, serving as many as one third. Some type of clinic or health screening and some type of counseling also reach about one-fourth to one-fifth of these elders.

It is interesting to compare these figures with those showing estimates of need for services (Table 4-6) or the incidence of problems which imply a need for services (Table 4-5). This must be done with caution, however. It is quite possible that the figures on services received may be higher than the estimates of need, but that a large amount of unmet need may still exist. Some types of services, such as congregate meals or transportation or a recreational program, if they are present at all, are usually available to all residents of a development. They may therefore be used by a much higher percentage than those who most acutely "need" them. (Indeed, for economy of scale, participation in congregate meal programs is often near-mandatory.) On the other hand, of course, if these programs are <u>not</u> present in a development, then they are not available to any residents.

Similarly, some services may be received by residents who need them less but not by those who need them most. Participation in a counseling or case management program, for example, often hinges on the client's taking the initiative to request the service. Meals-on-wheels, homemaker, health clinic, and visiting nurse programs often require the same initiative. Residents who step forward receive the service; those who do not, will not, or cannot step

forward remain unserved, regardless of how much they may need help.

Those areas in which estimates of utilization fall most clearly below estimates of need are transportation programs, programs to overcome social isolation (friendly visitors or peer assistance), and programs to deal with alcoholism. Figures for meals program, medication and health monitoring, and social or recreational programs are approximately comparable. That is, the percentage using such programs is about the same as the percentage needing them. However, as noted above, this may have little relationship to the extent of unmet need. We now turn to a direct examination of data which estimate the extent of such need.

4.7 Unmet Need

Managers and service providers responding to the Development-level survey were asked to provide estimates of the seriousness of unmet needs, taking into account services available to and used by elder residents in the sample developments. Respondents were asked to rank need for various services. Table 4-10 reports the results, distinguishing between needs that were ranked as "major" (e.g., 1, 2, or 3, where 1 represents "most needed") and those that were mentioned at all, regardless of rank.

Among managers, the needs most often identified as major were for transportation (cited by 56.3 percent of managers) and for homemaker services (53.1 percent). Close behind were alcoholism treatment (46.9 percent), visitors, and social/recreational programs (both 43.8 percent). About one-third of the managers named meals-on-wheels, visiting or public health nurses, and health screening clinics. The need for counseling/case management and for

Table 4-10

Extent of Unmet Need for Services

	Percent of respondents...			
	Managers		Service Providers	
	Major Need	Mentioned	Major Need	Mentioned
Meals-on-Wheels	34.4%	71.9%	16.7%	54.2%
Congregate meals	18.8	50.0	16.7	50.0
Social/recreational program	43.8	81.2	29.2	62.5
Transportation program	56.3	75.0	75.0	87.5
Homemaker/home health aide	53.1	75.0	41.7	62.5
Public Health/Visiting Nurse	31.3	59.4	33.3	54.2
Health screening/clinic	34.4	68.7	25.0	58.3
Friendly visitors	43.8	78.1	33.3	67.7
Counseling/case management	25.0	65.6	29.2	62.5
Alcoholism treatment	46.9	68.7	20.8	58.3
	N=32		N=24	

Source: Development-level instrument

congregate meals were least often cited, but were still identified as major needs by 25 and 18.8 percent of managers, respectively.

Service providers agreed in ranking transportation as the most common unmet need and homemakers or home health aides second. Service providers named transportation as a major need much more frequently than managers, and named alcoholism much less often. In general, service providers saw a slightly lower level of unmet need than managers, though the responses are not very different. This may be linked to the tendency noted in earlier sections for service providers to overestimate--relative to managers--the extent of services available to elders in public housing.

Perhaps the most striking aspect of Table 4-10, however, is that every type of service was identified as an unmet need by at least half of all respondents, both among managers and among service providers. It is clear that, in the opinion of these respondents, services of all types are not adequate in most developments.

4.8 Obstacles to Elders' Receiving Services

Given the extent of unmet need identified above, it is important to ask why some elders living in public housing do not receive the services they need. In theory, there can be many reasons. Services may simply not be available. They may be available through fee-for-service programs that these low-income elders cannot afford. On the other hand, the eligibility cutoff line for some programs may be so low that some elders are over-income. Elders may not be able to reach off-site services because of a lack of transportation. And some residents may not take the initiative required to obtain services.

Managers and service providers were given a list of possible reasons why residents may fail to obtain services. Again, they were asked to check any reason they thought to be applicable and to rank-order them. The results are shown in Table 4-11. Three barriers were listed as major by half or more of the managers:

- elders' physical or emotional impairments (55.6 percent)
- lack of systematic assessment of...needs (52.8 percent)
- elders' income is inadequate (50.0 percent).

Four other reasons were cited as major barriers by more than 40 percent of the managers who responded:

- insufficient services available in community or on-site
- insufficient coordination of services by provider or PHA staff
- inadequate outreach by providers
- elders' fear of dependency.

"Insufficient information and referral" and "inadequate transportation to service delivery site" were considered major barriers by one-third of the managers.

Service providers' responses were somewhat different from those by managers, though not necessarily in disagreement with them. Providers' responses were less uniform than those of managers, with some higher and some noticeably lower. Six reasons were cited as major barriers to service delivery by providers:

- lack of systematic assessment of...needs (75 percent)
- inadequate transportation to delivery site (62.5 percent)
- elders' income is inadequate (54.2 percent)
- elders' fear of dependency (54.2 percent)
- elders' physical or emotional impairments (50 percent)
- insufficient services available in community or on-site (50 percent).

In general, the two lists are in substantial agreement. The managers give more weight than the service providers to barriers which might be held to be the responsibility of a provider rather than a houser--"inadequate outreach by providers" and "insufficient

Table 4-11

Obstacles to Service Delivery

	Percent of respondents...			
	Managers		Service providers	
	Major barrier	Mentioned	Major barrier	Mentioned
Insufficient services available in community or on-site	44.4%	58.3%	50.0%	79.2%
Lack of systematic assessment of elder residents' needs	52.8	80.6	75.0	58.3
Insufficient coordination of services by provider or PHA staff	44.4	69.4	20.8	58.3
Inadequate outreach by providers	44.4	75.0	20.8	54.2
Insufficient information & referral services or assistance in requesting services	33.3	69.4	16.7	54.2
Inadequate transportation to the delivery site	33.3	61.1	62.5	79.2
Elders' income is inadequate	50.0	75.0	54.2	67.7
Elders are over-income for services	19.4	41.7	8.3	29.2
Elders' fear of dependency	44.4	80.6	54.2	83.3
Elders' physical or emotional impairments	55.6	91.7	50.0	87.5
Language or cultural barriers	22.2	63.9	0	37.5
Other	0	2.6	0	4.2
	N=36		N=24	

Source: Development-level instrument

coordination of services". The providers place more blame on inadequate need assessment and transportation to reach off-site services--matters that might seem more the PHA's responsibility to organize. (In fact, service coordination is often done by PHA staff, and both need assessments and transportation are often done primarily by outside providers. Therefore these generalizations should not be taken as prescriptive.) Managers agree that lack of adequate need assessment is a problem, though they rate it considerably lower than do service providers.

In addition to factors which are clearly the responsibility of PHAs or service providers, both groups agree that several characteristics of the elder residents themselves hinder delivery of adequate services. "Elders' physical or emotional impairments," "elders' fear of dependency," and "elders' income is inadequate" are all given as major barriers by large numbers in each respondent group. These responses have important implications for the design of service programs. Clearly, nothing is gained by <u>blaming</u> elders' fears and impairments for inadequate services. Much may be gained, however, by <u>recognizing</u> these factors as part of the reality that both PHAs and providers face in serving elders. Some residents are physically impaired and cannot easily reach a service delivery site without appropriate transportation--wheelchair-accessible vans, for example, rather than public buses which run some blocks from the development. Other residents may be mentally confused--unable to handle the "red tape" involved in requesting and obtaining services, especially from a variety of uncoordinated agencies. Others may be fearful to admit problems to the PHA for fear that their tenancy may be threatened. Others--alcoholics, for example--will

be reluctant to admit problems to anyone, even to themselves. And some cannot afford services that are available only for a fee.

Some of these problems will affect a large proportion of residents. Others may affect only a few individuals, but those few may be most at risk. Taken together with other responses, they point to the advantage of adequate need assessments--also recognized by survey respondents as a major barrier. Too often, service delivery starts at the wrong point--with a list of services that are available, or with an assumption about what some residents need, or with a notice that funding is available to carry out a particular program. Then a need assessment is done to justify an application for funding.

This approach tends to lead to gaps and overlap. Various providers offer the services they are funded to offer, but do not coordinate with the PHA or other providers. Services may be available somewhere, but elders may not be able to reach them. Elders who cannot take the initiative to ask for services may remain invisible. Major needs may be unrecognized.

An adequate need assessment can at least identify problems of this sort, as a guide to where resources can best be directed. In most cases, the PHA is probably the logical party to see that such an assessment is done--though it might actually be carried out by another qualified group or agency. It also seems important that PHAs develop systems for monitoring the needs and service utilization of their elder residents on an ongoing basis. Such monitoring can help update needs assessments that otherwise become obsolete as needs and service offerings change.

These and other implications of our findings will be discussed at more length in Chapter 6, "Conclusions and Recommendations". We now turn to a discussion of concrete ways in which PHAs and elder service providers are working to help elders live independently longer.

5.0 APPROACHES TO MEETING ELDERS' SERVICE NEEDS

5.1 Overview

Prior chapters in this report have presented data gathered by CHPA's surveys of PHA administrators, development managers, and elder service providers. This chapter, in contrast, contains a number of case studies based on more detailed descriptive data obtained from a number of the PHAs which were included in the survey. Many PHAs, in completing the survey or in talking with us about it, reported projects or comprehensive programs to serve elder residents. We reviewed this information, chose 23 PHAs, and spoke by telephone with administrators, managers, or program coordinators. Our intent was to obtain brief, accurate descriptions of programs, including design, funding, staffing, scope, and the PHA's assessment of strengths and weaknesses.

This chapter is by no means exhaustive. We did not have the time or resources to contact every PHA which is doing something interesting or innovative to serve its elder residents. We selected those which seemed to offer particularly clear examples of ways to serve elders, from single-purpose programs at one development to coordinated approaches at the PHA level. Nor have we had the resources to document any program fully. Persons who wish to learn more about the programs described here can do so by contacting the PHAs involved.

After this overview section, the chapter continues with a discussion of the range of overall approaches PHAs can and do take to housing and serving elders (section 5.2). Section 5.3 describes large, comprehensive programs developed by housing authorities. Section 5.4 presents examples of smaller-scale or less formal

programs which nevertheless provide a comprehansive array of services. Section 5.5 presents examples of specialized programs or program components which address one aspect or another of elders' needs.

Thinking about Program Components

Even if a PHA does not take responsibility for services to elders, or does not have the resources to develop a comprehensive system, it will do well to consider the options in a systematic manner. That is, questions should be asked and answered about the various "pieces of the puzzle" that might be brought together into a program:

- How are the needs of individual residents and/or applicants assessed? By PHA occupancy staff? By professional gerontologists from a community agency? Using what criteria? When does this take place?

- How is an individual's status tracked over time? How are events such as a medical, emotional, or economic emergency noted and evaluated?

- How are individual data combined to produce aggregate assessments of need?

- How are individual data used in making occupancy decisions? Who makes such decisions? Should family, physician, service providers, or elder advocates be involved? Regularly or case-by case? If others are involved, what responsibility do they take for the resident's tenancy and changing needs?

- Is there regular communication between PHA staff and community service providers about individual residents? About needs of the resident community as a whole?

- What role will the PHA take in service provision? Will it make space available to a community agency? Provide staff to make referrals? Provide service coordinators to help match residents and available services? Hire staff to deliver services directly to residents? Build additional facilities for some types of residents--e.g., those who need a more service-enriched environment, or even those

who need nursing home care?

- How are the space and units available to the PHA adapted to elder residents' needs? Should moves or modifications be considered?

- What training should various types of staff receive about how to deal with elder residents and their problems? Should procedures be developed to avoid "reinventing the wheel" in many individual cases?

- How well do services available in the community match the needs of elder residents? Are there major "gaps". If so, who should take the initiative in thinking about filling them? Are there services that are oversupplied? Can those resources be better used?

It is clear that many PHAs have become increasingly concerned about such questions as the average age of their residents increases and the needs of their elders become more visible. It is also clear that alternative housing for frail elders may be even less available in the future than it is at present: as pressure to contain the medical costs of aging increases, some of the common responses elicited by our survey (e.g.,"initiation of eviction proceedings" or "manager works with the family to make alternative [i.e., nursing home] arrangements") may become even more difficult to implement.

5.2 The Range of Approaches

The housing authorities which responded to our survey house elders in a variety of ways. This section presents two examples which illustrate how different these approaches can be. One is a PHA which has chosen to limit its resources to housing elders who are capable of independent living, and therefore does not attempt, except in a very liomited way, to take on the role of care-giver to elders who cannot stay in their units without special services. The second is a PHA which has developed an extensive capacity to

serve elderly tenants with various disabilities, and which actively recruits and accepts applicants who will need help living in public housing.

These examples represent two extremes. It should be noted, however, that both PHAs have chosen their approaches deliberately. Both are attempting to use their resources rationally and effectively to serve their eligible population. These PHAs do not necessarily represent the range found in all public housing, only that in PHAs who reported on programs to serve their elder residents. In many PHAs, elders may be isolated and needy without anyone's knowing.

A Low-Service Approach

Our first example is a very large urban authority in the northeast, beset by widespread deterioration of its physical plant, crime against the most vulnerable residents, and limited resources for making physical or social improvements. The PHA houses about 3,000 elderly households, about 2,000 of which live in large family developments scattered throughout the city.

This PHA's stated admission policy for the elderly is to accept only applicants capable of independent living, and to reject those with any "serious health problem" observed by PHA occupancy staff and corroborated by neighbors, previous landlords, and medical or social service personnel in contact with the applicant. Serious is defined as "any health problem experienced by the Applicant/Family Member that would make him/her unable to live independently or that would adversely affect the health, safety or welfare of others."

The application form is completed by a PHA staff person during a home visit. In completing the form, the staff member makes subjective determinations based on a list of required capabilities which very generally define "independent living." The form also asks whether the applicant is currently receiving any assistance which may be necessary and whether "the individual or agency involved has a commitment to continuing the service". This commitment must then be corroborated by the service provider.

These procedures attempt to screen out applicants whose limitations will make it impossible for them to live independently in public housing, thereby further contributing to the physical and social problems of the developments. Housing authority personnel have no stated responsibility to inform an applicant about services or to help in obtaining them. However, applicants whose existing services will "move with them" into public housing can be accepted. Even with these relatively strict policies, two thousand elders (including handicapped) are on a waiting list with average waiting periods of one year.

The PHA offers more assistance to current residents who must obtain services, but this assistance is minimal. Stated policy for continued occupancy is the same as initial occupancy: the resident may remain so long as he/she "can arrange for all [needed] supportive services" without reliance on PHA staff. In practice, current residents whose declining health and capabilities come to the attention of building managers (usually via the recertification process or neighbors' complaints) may be referred to the authority's Department of Community Services. A staff person in

that office refers the case to the local Area Agency on Aging, and that agency assesses the resident's needs and arranges for a plan of care.

In three developments--"buildings that the other agencies didn't want to go into"--the authority directly recruited and employed home care caseworkers under a contract funded by the local agency. However, in all buildings, including those served by the PHA's home care caseworkers, residents must compete with non-PHA residents of the neighborhood for limited services. The waiting period between assessment and care delivery is frequently six months or more.

The only other resource provided or arranged by the PHA is a Congregate Housing Services Program (CHSP) on one site. (CHSP is a special HUD-funded program which will be described later in this chapter). It serves only a small number of the current residents of that site, and residents of other buildings who need support are not put on a waiting list for transfer to this program. The PHA respondent explained: "There is such a big need in this building itself. It represents true aging in place--it was built in the early '70s and the average age there now is 77.9 years."

In summary, this PHA's response to the issues surrounding aging is highly constrained by unavoidable limits: provision of the best physical and social environment possible given limited resources and a long history of urban decay. Even within the limitations imposed by this approach, however, the reality of a growing but impoverished elderly population has forced the authority to adopt some measure of flexibility in its occupancy policies and to initiate small-scale attempts to provide services.

An Extensive Elder Service Approach

At the other end of the spectrum lies a housing authority in Birmingham, Alabama, one of the major industrial centers of the deep South. Despite racial tension in the '60s, the city experienced rapid economic growth from the turn of the century until the 1970s, producing a significant middle class population, both black and white. The city, only one-fifth the size of the one described above, has been spared much of the economic and social distress characteristic of many older urban areas.

The housing authority provides housing for slightly more than half (1800) of the number of elders served by the previous authority. The ratio of non-elderly to elderly residents is roughly equal in both authorities, and time spent by elder applicants on the waiting list is the same. However, where the northern authority had a waiting list of 2,000 elder applicants, only 200 elderly are among the 4,500 households on Birmingham's waiting list. While there can be many reasons for a large waiting list of elders, it may imply that the level of unmet need for elderly housing is greater in the northern city. If so, it may help explain why the northern PHA chooses to serve as many elders as possible rather than offering more services to a smaller number.

Birmingham, by contrast, has chosen to offer services both more intensively and extensively. Significantly, the PHA's stated policies also stress an independent living capability: "Applicants [must] be capable of complete independent functioning without any assistance"; and current residents who need assistance may remain if they themselves can arrange for it. In practice, the authority administrator told us, "Our target elderly population includes

especially the frail and the lonely--those who can no longer maintain themselves independently and whose families are unavailable to provide help."

Occupancy staff trained in assessing the elderly make home visits at the time of application and confer with other involved health or service providers in order to make determinations about the kinds of support the potential resident will need. Upon becoming a resident the elder will live either in one all-elderly development or one of eight "mixed" developments. A senior center operated with PHA staff and equipment (with some state reimbursement) is housed at each of the nine sites (or "project communities," as they prefer to be called), providing educational activities, social events, sports and exercise activities, field trips, and transportation services. Full-time professional or paraprofessional PHA social workers are at each site daily to monitor residents' needs, provide counseling, and provide information and referral services in order to obtain additional needed services such as homemakers. Security guards also routinely patrol the developments to ensure elders' safe access to and from the centers (those with mobility impairments are picked up and returned home by van). Space, utilities, and staff furnished by the PHA assist an independent senior citizens' agency which provides a meal five days per week and a snack program at each site.

Finally, two "adult centers," or adult day care programs, funded by the state's Department of Human Resources, provide a more intensive array of medical, nutritional and social services to 85 residents who can continue to live in their own apartments if they

routinely receive that level of care. (Other examples of adult day care will also be described in greater detail later in this chapter.) In total, over 900 elder residents take part to some degree in this package of programs.

In summary, the PHA's admission and retention practices in the face of elders' declining capabilities are highly flexible and inclusionary. Multiple management and social services staff--in and out of the authority--are routinely involved in occupancy and service decisions, and decisions are made on a case- by-case basis. Confronted by a lesser demand for "mere housing" (in comparison with the larger northern PHA described above), the PHA has come to view its role as <u>including</u> advocacy and service responsibilities toward its elders. In this spirit it has aggressively sought out and obtained fiscal and material resources from the outside community, and, when necessary, "dug into our own pockets" to meet the needs.

A Spectrum of Approaches

Birmingham is one PHA among the roughly 8 percent of survey respondents from across the country whose responses to the phenomenon of "aging in place" can be described as comprehensive, highly organized, and flexible. (By "comprehensive" we mean that they provide an array of services which are intended to fit together and to meet a variety of common needs. By "highly organized" we mean that they are based on standardized procedures, and coordinated among the different providers that are involved. By "flexible" we mean that they are able to adapt to individual situations and to differing levels of ability to live independently.) Additional examples of such programs are discussed in Section 5.3 below.

Another eight to ten percent employ approaches which are equally service-oriented but less formally organized or somewhat smaller in scope. Example of these programs are discussed in Section 5.4. Following that, briefer "capsule" descriptions of particular types of programs will be presented in Section 5.5; for example, innovative health programs, varieties of "congregate" housing, and volunteer and tenant organization programs.

Because so many cities, programs, and program components are discussed in the various sections in this chapter, it is useful to have a reference to descriptions of various program elements. Table 5-1 provides such a guide. It is organized by type of component and lists PHAs whose programs have been included for discussion in this report, together with the section in which each is discussed. (Table 5-1 is found on the following three pages.)

We believe that these examples provide a useful framework to help housing authorities think about their own situations and options. Diversities of size and age, PHA leadership, local funding arrangements and political structures, the extent to which local service providers are willing and able to develop programs to serve public housing residents, the impact of the community's social and economic problems, the willingness of private foundations and corporations to enter into partnerships with public institutions--all of these factors and many others will shape the options which are possible.

Despite these influences, however, our examples show that housing authorities <u>can</u> develop programs which encourage aging in place even under very constraining circumstances. In fact, very

THIS PAGE INTENTIONALLY
LEFT BLANK

Table 5-1

Program Descriptions Included in this Report

1. Home Care, Personal Care - Includes simple homemaking services such as cleaning, laundry, meal preparation, and shopping; also assistance with bathing, shaving, and other aspects of personal grooming. Congregate housing programs which include these services are listed separately below.

Baltimore	- 5.3
Cambridge	- 5.5
Columbia	- 5.5
High Point	- 5.4
Mobile	- 5.3
Rochester	- 5.5

2. Nutrition - Includes food buying and congregate meals not a part of broader multipurpose centers or congregate housing facilities. Note that congregate meals programs also frequently include social or recreational components.

Baltimore	- 5.3
Birmingham	- 5.2
Chattanooga	- 5.4
High Point	- 5.4
Minneapolis	- 5.3
Mobile	- 5.3

3. Health Care - Includes on-site or accessible clinics providing one or more of the following: physical examinations, health screening (e.g., blood pressure), assistance with medications, medical information and referral, nutrition education, or fitness programs.

Akron	- 5.3
Chicago	- 5.5
Greensboro	- 5.4
Milwaukee	- 5.5
Minneapolis	- 5.3
Mobile	- 5.3
Omaha	- 5.5

4. Senior Centers - Includes some combination of social and recreational services, meals, information and referral, transportation, and health or fitness services.

Birmingham	- 5.4
Chattanooga	- 5.4
Minneapolis	- 5.3
Mobile	- 5.3

5. Adult Day Care - Programs at a centralized site which provide social, nutritional, and other medical or therapeutic services to the elderly and/or handicapped on a regularly scheduled basis, ranging from one day per week to daily. Transportation to and from the site is usually provided.

Baltimore	- 5.3
Birmingham	- 5.2
Knoxville	- 5.4

6. Congregate, Sheltered, and Enriched Housing - Living arrangements which include provision of some combination of meals, household care, mutual assistance, help with shopping and transportation, personal care, counseling, and occasionally health aides.

Baltimore	- 5.3
High Point	- 5.4
Minneapolis	- 5.3
Rochester	- 5.5
St. Paul	- 5.4
Syracuse	- 5.5

7. Counseling, Information and Referral - Includes special programs not a part of some larger effort such as a senior center or health program, except as noted.

Akron	- 5.3	
Birmingham	- 5.2	
Boston	- 5.3	
Chattanooga	- 5.4	
Greensboro	- 5.4	
High Point	- 5.4	
Knoxville	- 5.4	
Minneapolis	- 5.3	(See Senior Citizens Center, Inc.)
Mobile	- 5.3	
St. Paul	- 5.4	

8. Resident Councils - Includes social and recreational services, security programs, and others in which tenant groups are involved in planning, coordination, or monitoring of services.

Boston	- 5.3
Charlotte	- 5.5
Minneapolis	- 5.3

9. Security Programs - Includes programs in which additional security is provided by residents, police, or guards.

Birmingham	- 5.2
Cambridge	- 5.5
Chattanooga	- 5.4
Minneapolis	- 5.3
Oakland	- 5.5

10. Volunteer Programs - Includes programs in which services are provided by PHA residents themselves, by community organizations such as churches, or by the business community. In some programs, elders also go out to provide services to others in the community. Services provided by volunteers include help with chores and home care, companionship, transportation, recreation, and improvement of physical facilities and equipment. Note that health care and security programs often are based on volunteers; these are listed separately in this table.

Houston	- 5.5
Little Rock	- 5.5
Minneapolis	- 5.3
Mobile	- 5.3
Nashville	- 5.5

few enjoy the circumstances which permit optimum solutions. The majority who described their programs impressed us with the fact that many are primarily a matter of initiative and creativity on the part of the housing authority in instituting simple, low-cost programs and leveraging materials and in-kind resources from the community, often in a piecemeal fashion. The result can nevertheless be a significantly more supportive environment for elders.

Housing authorities at the end of the spectrum of responses characterized by integrated and comprehensive systems for both assessment of individual needs and provision of services often have well-developed procedures, roles, and responsibilities. They allow for flexibility in decisions about occupancy, and tend to be inclusive in accommodating elders whose capacity for independent living is impaired to some degree.

At the other end of the spectrum are those authorities whose occupancy criteria for both admission and retention include higher or more rigid standards for independent living capabilities. These authorities' primary goal tends to be management of a large and complex real estate operation; service provision may be seen as secondary to the "landlord" function, rather than as a goal in its own right. Procedures for assessing applicants' or residents' capabilities are often not well-defined, and occupancy decisions are more often left to a single person or PHA department. (By contrast, the more service-oriented PHAs often have procedures which require bringing in family, assessment specialists, or community elder advocates to assist the PHA and the resident in occupancy decisions.) Similarly, the PHA staff's role in obtaining services which prolong the independence of residents is usually

limited, consisting more of ad hoc responses to pressing problems than of planned and systematic attempts to obtain resources.

In fact, most authorities exhibit a mixture of characteristics, and none, including the two examples with which this chapter began, are "pure" examples. Most contain paradoxes or compromises, and most are in transition. The direction of change, interestingly, often appears as a discrepancy between formal policy statements and actual procedures, or as a gradual augmenting of the responsibilities of some staff to include gerontological training and networking with elder service providers in the community.

5.3 Other Comprehensive, Large-Scale Programs

As noted previously, housing authorities whose programs fall into this category made up slightly less than 10 percent of the survey respondents. The "defining characteristics" of the category include:

(a) A well-defined, usually professionalized assessment process is used--(i.e., independent living criteria determined by health or social service professionals). Typically these criteria are applied in a standardized home visit format by trained social services staff, both in the case of new applicants and current residents.

(b) Multiple individuals are involved in occupancy decisions if independent living issues are involved--PHA management and social service staff, the applicant and his/her family, physicians or community health agencies, and other outside elder service agencies. The PHA exercises a primary responsibility for initiating or

coordinating this process, and decisions are often subject to appeal (sometimes pending the obtaining of necessary services).

(c) A wide range of supportive services is provided, often including meals, homemakers, transportation, educational and recreational services, health services, and social services. These may be provided under various arrangements by PHA staff or outside agencies at on-site senior centers; or they may be obtained from off-site agencies through a formal and highly developed information and referral system using PHA services staff and contractual arrangements with providers. In other words, the PHA takes an active role in solving problems and obtaining services, both on a case-by-case basis and in the aggregate (though in some cases for current residents but not for applicants). PHA staff have defined responsibilities for carrying out this role, and procedures are generally formalized in job descriptions and contracts (for services, space, utilities and the like).

Not all housing authorities cited in this section fully meet this description. However, all possess these characteristics in sufficient measure to stand apart as a category.

Baltimore, Maryland

The public housing managed by Baltimore's Department of Housing and Community Development serves over 5500 elderly households. Seventy percent live in fourteen elderly or four "mixed" elderly/family developments. The remainder are dispersed among conventional family developments. (A "mixed" development is one which contains both family units and units especially built for the elderly.) The authority-wide ratio of elderly to family units is

1:2. Policies and practices related to application and retention of the elderly are both consistent and highly "open" to frail elders. The waiting list for elderly units contains over four thousand households, and turnover rates are so low that time on the waiting list is two to four years, depending on unit size.

The authority's accepted occupancy policies (as stated in our survey, though not formally stated elsewhere) are that applicants may be offered units, and current tenants may remain, "if they need ongoing assistance, even if they must rely on PHA staff to arrange for these supportive services." (Emphasis added.)

Through a variety of funding sources and special contracts the authority has built a composite program of services which is not only authority-wide in scope, but capable of offering incremental levels of care. New programs are also under development on a continuous basis. Applications from elders are referred routinely to the Division of Tenant Services whose social workers carry out a joint assessment process with staff from the geriatric evaluation service of a local public health department.

Applicants who are fully capable of independent living or have in-place services which will move with them are wait-listed for general elderly housing. Applicants with special needs who agree to accept a service which is not currently available are put on a separate waiting list: in these cases the offer of a unit depends upon the service being secured. The PHA reports that waiting time on these special lists is about the same as on its normal list.

Every housing development (not just those which are locations of special programs) is assigned a social worker from the Division of Tenant Services whose hours on site are dependent on the size of

the development. These workers, together with the managers, learn of the needs of current elder residents through social activities, home visits, and other informal contacts. As necessary, assessments and "internal referrals" are made for special services (again, contingent on the resident's willingness to receive help).

The overall service program includes the following elements:

(a) "Food buying clubs" are organized in each development. Similar to food co-ops, these provide bulk grocery shopping and distribution services to residents who pay a small membership fee. The housing authority provides an organizer/facilitator and a driver, but food purchase and distribution are handled by resident volunteers.

(b) Personal care is provided in-home to residents needing and eligible for medical assistance programs. Funding from the state's Department of Health and Mental Hygiene pays for seven registered nurses who are direct PHA employees. They provide case management, including individual assessments and assignment and supervision of personal care providers. The providers, who may be neighbors or relatives, receive training and certification from the state, and operate under a "plan of care contract" between the resident, case manager and themselves. Services include homemaking (such as laundry, meals, and light housecleaning), help with personal care, and some health monitoring and assistance with medications (though not administering of them). Providers are paid directly by the state, with fees based upon units of care (hours per person per day). This program currently serves approximately fifty residents, who may receive help up to seven days per week.

(c) In-home aides provide basic homemaking and escort assistance to residents not needing or eligible for medical assistance. A contract with the local Department of Social Services funds PHA staff on a case-by-case basis to provide homemaking and personal care services as well as transportation to medical appointments, one or two days per person per week. A new program, it currently services fifteen residents but approximately fifty more authorizations (from the DSS) are in process.

(d) Adult day care (non-medical) and adult medical day care are provided at five sites (both programs co-exist at four sites, one is exclusively medical). Combined, these programs service 130 residents on any given day, but since individual plans of care vary from participation two days a week up to five days a week, the total number served is approximately 200.

The two types of programs differ in funding mechanisms (one receives Title 19 funds), eligibility requirements, and type of staff and services provided. Both provide social and recreational

programs run by activity coordinators, social work services by the center directors, a full meal and two snacks each day, and transportation to and from the centers in lift-equipped vans. The medical programs provide, in addition, physical and occupational therapy and daily medical supervision by a registered nurse.

(e) Congregate and Sheltered Housing. These types of programs will be discussed more fully later in this chapter. The two differ primarily by funding sources and related governing regulations. In brief, the federally funded CHSP program provides two to three meals per day but only limited personal care and chore services (one-and-a-half to two hours per person per week) for which some residents contribute on a sliding fee scale. A Professional Advisory Council, including authority staff but independent of the housing authority, makes final eligibility determinations and the non-elderly disabled may be included. Baltimore has fifty-five congregate units at two sites within larger elderly developments.

The Sheltered Housing Program combines funding from various governmental (principally state) elder service programs, and its design and eligibility criteria are largely under the control of the housing authority. It therefore has more flexibility in the kind and amount of services which can be provided, and can be targeted to those elderly with serious and worsening functional deficiencies. Its twelve sites (soon to be thirteen) serve approximately 250 residents and are located within the conventional elderly and "mixed" developments. Together with the congregate program, this means that almost every development serving large numbers of elderly can offer some higher level of supported living to its own residents even if they must be wait-listed for these programs.

Baltimore: Program Directions and Goals

Throughout its policies and programs for the elderly Baltimore's housing authority has consistently made it clear that sheltering, protecting, and prolonging the "supported independence" of elders is its primary goal--even though in this case nearly as many elders are waiting for housing as receive it. Its focus in program development is to enlarge the care-giving services, rather than the "enrichment" services--thereby prioritizing the needs of the frail. As we will see, other authorities with model programs have made different choices based on other goals.

At present, Baltimore is working toward a logical next step:

development of a "Very Sheltered Housing" facility. For those with emotional and behavioral problems or health problems needing greater attention, in addition to the more usual functional deficiencies, this program would provide 24-hour supervision as well as more medical and non-medical support. Proposals have been submitted to a number of funding sources. Said our respondent, "Our goal is to coordinate our programs and offer them on an incremental basis, for example combining CHSP with our personal care service to provide a higher level of care. With the proposed Very Sheltered Housing program we feel we could skim off a good percentage of those who now move prematurely into nursing homes and continue to serve them in their own community."

Minneapolis, Minnesota

Slightly over 5,000 elder households live in the 43 elderly developments of the Minneapolis Community Development Agency (MCDA). A small number of other elderly live in six family developments or row-houses. Authority-wide, the ratio of elderly to family units is greater than 3:1, and forty-one of the elderly developments are between eleven and twenty-five years old. In other words, this is a housing authority whose tenancy is heavily weighted toward the elderly. The waiting list holds only 300 elder applicants and waiting time for elderly units is "only processing time, 30 to 60 days," for the PHA's studios and one- and two-bedroom units.

Like Birmingham (but unlike Baltimore), Minneapolis has a short waiting list for elderly units. This may suggest that the overall need for conventional elderly housing is stable or declining and

that keeping the authority's present housing stock filled is a matter of concern. (The survey noted that the top two problems in elderly developments are, simultaneously, vacancies and "obtaining alternative placements for tenants . . . .") The authority's adaptive response to these changing conditions, both in modifying its occupancy procedures and taking on new roles in service delivery, provides a useful model for other authorities confronted with similar circumstances. (However, the authority notes that its vacancy rate in elderly units has been down to three percent for the past few months.)

The MCDA's lease agreement states clearly that applicants must be able to "live independently without special assistance from Agency staff members." Conditions leading to termination of occupancy are more general: for example "damage to premises," "failure to fulfill tenant obligations," and "other good cause." The lease focuses on management problems, not on tenant capability. Despite these seemingly restrictive policies, respondents stated both that applicants may be offered units and current residents may retain units "if they need ongoing assistance as long as they [themselves] can arrange for all supportive services."

In practice, the PHA takes individual circumstances into account and is able to respond flexibly within policy guidelines. (Many authorities in our survey were more flexible in practice than "on paper".) In 1980, the housing authority recognized that (a) the community's in-home supportive services system had developed markedly in the preceding ten years, that (b) the availability and coordination of services varied widely among neighborhoods, and (c) there were no uniform or objective guidelines for assessing elders'

needs by the agencies who had to develop joint support plans. The housing authority also adopted the view that, for both applicants and current tenants, occupancy with supportive services was preferable to institutionalization.

As a result the authority took the lead in convening a committee of professionals from the fields of social work, health care, senior services, and community services to develop a set of "Guidelines for Determining an Individual's Capability for Successful Independent Living." Agencies involved in developing the guidelines used them on a trial basis and in 1981 they were more systematically tested with public housing tenants through an interdisciplinary health care program at the University of Minnesota.

The guidelines provide for a quantitative measure of an individual's ability in twenty activities or "functions," on a three-level continuum ranging from independence to dependence. The first ten functions are called "basic living functions" and are considered essential for independent living. The second ten are "secondary living functions"--less crucial, but helpful "in the evaluation of a marginal situation." Through a series of questions related to each function, the individual's ability in each is determined to be at a "level of independent living," "level of independence with supportive services," or "level where an alternative living situation should be considered." If these guidelines suggest types and levels of support services which are needed either for occupancy or transition to alternative care, a second set of questions identifies the individuals or agencies whose help is available or needs to be obtained.

Directions for the use of these materials repeatedly stress that they are guidelines only--"a tool to assist professionals or paraprofessionals, who have varied skills in interviewing, to make their determination." They are used to evaluate applicants as well as current residents, and to help authority and agency staff coordinate the service packages which these elders need. Because of the inevitable subjectivity of interviewers' judgments, two or more staff are always involved in making evaluations which will result in an occupancy decision. In addition to matters specifically requested by the forms, workers are also encouraged to seek out any other relevant factors.[1]

Social workers called "community services specialists" with the authority's rental office carry out the application interviews during home visits. Independent assessments are made by social workers from the county community services agency. If support services are needed but not in place, the PHA staff with staff from that agency or a variety of other community agencies will work with the applicant to obtain the services (the applicant's participation must be voluntary, and the services arranged prior to rental).

Assessment of current residents is set in motion by referrals from on-site social workers (described below), referrals from building "caretakers" (maintenance staff--developments don't have site managers per se), or resident complaints. In this case the assessment guidelines are used by a Community Services Department

---

[1] Sample summary sheets and questionnaire pages are attached to this report as Appendix C. For more information or for a full set of these materials, contact the Public Housing Director, Minneapolis Community Development Agency, 331 Second Ave. South, Suite 600, Minneapolis, Minn. 55401.)

(PHA) social worker, on-site social worker, and any other agencies' staff who are involved with the resident. Again, assessments are done independently, followed by case conferences--to deal with getting more services, coordinating services better, or moving toward an "alternative living situation" for the resident.

According to the PHA respondent, the authority is able to be much more flexible than it was in the past about accommodating elders with differing levels of need. The PHA's role in service provision may be described as a highly organized and broad-based information and referral system, intended to increase services for residents, rather than as a large-scale direct service program carried out by its own staff, such as the program in Baltimore.

Minneapolis's service program consists of the following elements:

(a) Senior Citizens Centers, Inc., an independent community agency, has a contract with the authority which provides social workers in each elderly development (time on site ranges from 3 hours per week in a 28-unit building to 40 hours per week in a 500-unit high rise). These "coordinator social workers" provide basic counseling, information and referral for other services, and assessments as described above. With the Resident Councils they also plan and run a variety of social and recreational programs in the buildings' community space.

(b) Senior Citizen Representative Council consists of elected officers who represent individual Resident Councils in each building, further organized by geographic area. At the building and area level the Councils plan programs and outings and are generally geared to education and enrichment. The Representative Council works with the housing agency administrators as well as its area-based member Councils to give resident input on policy and procedural changes affecting elders.

(c) Security is provided in seventeen building locations by private professional security guards funded out of Payments in Lieu of Taxes (PILOT) and the PHA's general fund. Next year, the authority hopes to use some Community Development Block Grant money as well.

Further, the authority, telephone company, and Senior Citizens Centers, Inc. jointly support and promote an "I'm O.K." program in each building which is voluntary but has a high level of participation." Elders put cards out on their doorknobs each night and take them in in the morning. If a card is not taken in by a certain time, a volunteer "checker" on each floor checks on the resident by phone or visit and calls the building caretaker if there is a problem or no response.

(d) Health Care is provided by senior nursing students from the University of Minnesota School of Nursing. The school pays the costs ($4000, for equipment and supplies) for students to go into five of the large buildings twice a week during the school year. There they provide medical monitoring and assistance, exercise and nutrition classes, group counseling on issues of aging (such as loss and grief), "even take people on walks." Because of the value of this program, the authority has just persuaded the school to carry the program through the summer with donated faculty. Funds come from the PHA, a Community Action Agency, the University of Minnesota, and another local agency.

Minnesota Visiting Nurses, working out of various hospitals, also provide a nurse in each building for times which range from one hour to two days per week.

(e) Meals are provided at eleven sites by the Volunteers of America, with United Way funding. These meals are available for all elder residents who have or can arrange for transportation (the authority does not provide transportation to them).

(f) Congregate Housing is provided in sixty units located within a conventional elderly high-rise. This program combines funding and personnel from the federal CHSP program, the county community services department and the authority itself. Residents pay on a sliding fee scale for some services, especially those residents "over income" for public homemaker and medical assistance programs.

The program is therefore more extensive in what it provides than those congregate programs limited to federal CHSP funding. It includes meals, homemaker/chore services, home health aide/home nursing, counseling and case management, and 24-hour emergency response. At present, all public housing elders in buildings in the vicinity of the program who need such care can be transferred into it fairly readily. The authority is beginning to think about a similar program "on the south side" for elders whose own geographic preference inhibits their access to the program.

Minneapolis: Program Directions and Goals

Minneapolis's newest program initiative is called "Adopt a High Rise." Authority staff went to the city's Corporate Volunteer

Council to propose that specific corporations and businesses "adopt" an elderly building to which they would provide funding and volunteers. Now in the process of being set up, this program will provide equipment for the community space, bring in special recreational programs, organize employee volunteers for companionship, shopping, and general transportation assistance, and even offer to help with apartment fix-up.

In summary, Minneapolis's primary program goals are enriching "the quality of life"--including improving the security of elder residents--rather than widespread in-home caregiving to the frail. There is a system in place for helping elders obtain such care, but there is still an emphasis on moving those who are assessed as very dependent to other situations with higher levels of care.

Minneapolis's program development is particularly noteworthy for its adaptable and incremental approach, marked by building community alliances, creativity in finding, obtaining, and combining resources, and enlarging the role and status of volunteers (including residents). The result is a large-scale, integrated "program" through which the living environment is improved for the vast majority of elder residents, the community is made more aware of elders' needs, and resources are more readily available.

Akron, Ohio

The Akron Metropolitan Housing Authority (AMHA) offers useful comparisons with Minneapolis, especially with regard to assessment and case management procedures. Like Minneapolis, Akron has developed an ambitious service program in which direct services are delivered primarily by persons or groups other than the PHA itself.

The cornerstone of Akron's approach is its participation in a computerized community-wide system of assessment, referral, and case management: the Program for an Integrated System of Community Elder Services (PISCES). A second key element is the PHA's centralized Human Services Department. Development managers are able to refer tenants with physical, emotional, social, or economic problems to the central tenant services staff. These staff members, in turn, are able to obtain assessments, information about services being delivered by any one of 35 agencies, and to make referrals to participating agencies through the PISCES Project. They also have informal information-sharing and referral relationships with over fifty non-PISCES agencies. Problem identification, case management, referral, and service delivery are therefore coordinated at the community level rather than at the level of any one agency, including the PHA. The AMHA feels that this greatly expands the service options available to its elder residents and staff.

Akron houses over 2,000 elder households in fourteen elderly developments, with another two hundred concentrated primarily in three family developments. The overall ratio of elderly to family units is 2:3, a fairly typical balance among our respondent PHAs. As in Minneapolis, the great majority of elderly developments is eleven to twenty-five years old, signaling the likelihood of an "older" elderly population. Approximately 500 elder households are on the waiting list, but because of the large turnover of units (over 20% annually, largely through death or moves to higher levels of care) length of wait is generally only two months (again, normal processing time). In short, as in Minneapolis, the housing

authority's need is moving in the direction of keeping units filled--which can be accomplished by providing support which prolongs the tenancy of current residents, or admitting applicants who need some level of assistance. This implies an elder population with increasing service needs.

Akron: The PISCES Project

Several years ago a small, informal group of elder services providers in the Akron community, including the housing authority, began meeting regularly "to talk about turfism, interaction, and gaps in services." Other agencies joined the group, "people got to know each other", and the result was a successful proposal to the Robert Wood Johnson Foundation to create a central coordinating body, joint assessment procedures, and a mechanism for sharing information about the services being provided to individual clients.

Clients must formally agree to this collection and pooling of information, and services cannot be withheld because they don't wish to participate. In practice, however, providing assessment information one time to one agency has spared individuals the added intrusion and inconvenience of having to provide such information each time they deal with a different agency.

The project now consists of thirty-five agencies--housing, home health, medical centers and hospitals, meals, adult day care, rest and nursing homes, social services, hotlines, public health, and human service agencies. The central coordinating body is composed of a representative from each member agency. Each agency signs a contract agreeing to use the same assessment procedures and

training materials as well as to share information. Information about clients and the services provided is maintained in a computerized databank accessible to all member agencies. The coordinating body operates with its own by-laws, committees (organizational issues, client services issues, training and education, legislation), and paid staff. It continues to be funded by the Robert Wood Johnson Foundation, with some additional United Way assistance. (Long-term plans are for increased assistance by the United Way and local funding sources).

Development of the assessment tool and training materials took nearly one year, as agencies hammered out a form which was "not just medical and not just social" and would serve the elder information needs of each agency. The form collects basic client identification and demographic information, medical history, listing of key people (e.g., physician, clergy, attorney), and consent statements. It also contains a three-level ranking of elders' abilities on items related to personal care, household tasks, legal and financial responsibilities, mobility, social relationships, and emotional and behavioral factors. It records assistance being provided at the time of initial assessment and also provides a format for recording ongoing information about agencies, workers, dates, disposition, and termination.[2] (Since the system is interactive and computerized, workers from all agencies can update and access information as events occur.)

---

[2] A sample page from this form is included with our report as Appendix D. However, the form and essential training materials for its use are copyrighted. Individuals interested in obtaining them or learning more about them may contact the PISCES Demonstration Project, 474 Grant St., Akron, OH 44311 (216/762-0308).

Participation and support for this project by the AMHA and the other members is based upon the assumption, borne out by the authority's experience, that coordination of information promotes more effective case management by any agency responsible for organizing a service package for an elder. Gaps and overlaps can be identified and priorities assigned, on the community and development level as well as the case level.

PHA staff do not duplicate assessment activities already performed by another agency, nor must they spend time trying to locate other workers involved in a case, or debate about who has the primary case management responsibility. In short, the authority's participation means that needed services can be more readily identified and obtained for its elder residents.

Akron: Program Directions and Goals

Both in stated policy and practice a distinction is made between applicants and current residents. The assessment and case management resources of the PISCES Project are directed primarily toward the increasing needs of current residents who are growing frail. Applicants "must be capable of complete independent functioning without any assistance" (arranged by PHA staff or others). Current residents, though, may remain even if they need ongoing assistance "as long as they can arrange for all supportive services." As noted above, the authority has assumed a major role in facilitating the arrangement of services by outside providers, in the interests of prolonging the independence of current elder residents.

The assessment tool used both to screen applicants and to

determine the needs of current residents is a product of the PISCES Project. When used to screen applicants--by occupancy and placement staff trained on the project--its main purpose is to screen out those whose level of difficulty on a set of "critical factors" is felt to exceed the "minimum requirements necessary to maintain independent living in AMHA housing." The questionnaire does obtain information about "frequency of available help with functioning"--by whom, how frequently, and with what function--and the PHA says, "no one has been denied occupancy solely based on this assessment." However, in marginal situations the role of PHA staff is only to explain to elders and their families what services must be in place before occupancy can be considered. In addition the PHA is working to develop another, more simplified set of guidelines which tie the independent living criteria to specific management concerns (e.g., housekeeping abilities, dress, and personal habits "acceptable for group living"). These guidelines would become the basis for official admission policy.

In summary, Akron's goal is to "oil the wheels" which provide services for elder residents through PHA participation in a large-scale, highly formalized information and referral system, rather than to sponsor or provide direct services. This approach has the merit of helping elder residents gain access to many service options, rather than limiting them to services provided or arranged directly by the authority.

The authority's newest program for elders is a "mobile pharmacy program," sponsored by a local pharmacy and Ohio State University. This program is specifically targeted to elders recently returned from health care facilities and uses a computerized pro-

file of their prescribed medications to help monitor self-administered use of drugs and avoid over- or under-medication. "This program has eliminated hundreds of emergency hospital visits by virtue of preventing misuse of medications," says the PHA. Here again, the authority offers assistance through a monitoring and coordination service, rather than providing basic health screening and medical assistance itself.

The existence of the PISCES Project in Akron offers other housing authorities the opportunity to learn from a model that has been developed and tested over several years and by many cooperating agencies, and which the PHA finds to be economical and efficient. PHAs which find this approach in accord with their goals and the realities of their situation--e.g., the ability to work cooperatively with a variety of community service agencies--may be able to save resources by adapting parts of Akron's procedures and materials.

Boston, Massachusetts

Boston provides interesting comparisions with several of the PHAs discussed earlier. Like the first PHA cited, the Boston Housing Authority (BHA) must contend with problems common in older urban areas--old, hard-to-maintain physical stock, heavy demand, crime, vandalism, and abandonment in many developments, and racial and ethnic tensions. Like Akron, the BHA has developed an approach to elder service needs that increases resident access to existing services--and even resident ability to influence the creation of new services--rather than the PHA's providing services directly. However, the approach is very different from Akron's. Boston's

model focuses on "tenant empowerment" supported by a BHA coordinator and a group of cooperating service provider agencies--the "Boston Consortium," described below.

Boston: The Setting

The Boston Housing Authority provides housing to nearly 6,000 elder households, 4,000 in 35 elderly developments (two-thirds over eleven years old) and most of the remainder concentrated in several very large, family developments. The overall ratio of elderly to family units is approximately 2:7. This is a high proportion of family housing. In the opinion of one authority respondent, the high proportion of family housing and the problems in many developments lead the PHA to focus its attention primarily on family housing. Over a quarter of the elders in elderly units are over 80 years old, and 50 percent over 75 years old.

Average annual turnover of units is 20 percent, 90 percent of those because of death rather than moves to other levels of care. This is a high proportion of exits due to death relative to other PHAs, and its meaning is unclear. It may reflect greater availability of home care in Massachusetts than in most other states, enabling large numbers of elders to remain at home indefinitely. It could also be because large numbers of elders needing health monitoring and support services are not receiving them, leading to unattended problems and crises. In a situation as diverse as Boston's, both factors probably play a role, depending upon the characteristics of a given neighborhood or development.

Approximately 1,500 elders are on the waiting list, but length of wait varies widely, depending on desired unit size and other

"attactiveness features". Some elderly developments are considered unsafe or undesirable by potential residents, and thus are more difficult to fill. The three greatest problems cited in our survey in elderly developments were alcoholism--which often accompanies depression and isolation--crime against residents, and vacancies.

Boston: Occupancy Policy and Practices

Occupancy policies regarding the elderly are flexible and generally open to applicants with service needs, reflecting both management concern for minimizing vacancies and humanitarian concern for assisting elders. Applicants may be offered units even if they need ongoing assistance, as long as these services are in place or can be arranged. The authority does not have a well-developed assessment process for applicants, but PHA staff often advise applicants informally about services that are apparently needed, telling them whom to call and how to apply, even though this is not part of their formal job description. Said one person, "If the applicant is 'help-rejecting' it's hard to get them in, but we have a high tolerance level." Another: "The BHA tends to give priority to those elderly in greatest need who may be physically [or economically] incapacitated."

Current tenants who need ongoing supportive services are often able to remain in their units because such services are available as a result of PHA practice and the Consortium process. However, not all developments are covered by the Consortium. (See description below.)

Background and Development of the Boston Consortium

As the result of a class action law suit brought by a group of housing tenants, the authority was put in the hands of a court-appointed receiver in 1982. Control was recently re-assumed by the city after a period of nearly four years. The judge, in his ruling, declared conditions in many developments unfit for human habitation, citing problems with all basic systems related to sanitation, utilities, safety and security. Escalating vacancies led to large blocks of empty vandalized units which were havens for drug dealing and other forms of crime. The agency's own management problems both reflected and contributed to the rapid decay of the city's poor and minority neighborhoods in a period of general economic stagnation and racial tension.

After sweeping authority was put into the hands of the receiver the agency underwent a period of massive management overhaul. New infusions of state and federal funding, some gradual local economic growth and easing of racial tensions have all contributed to an improved internal and external housing climate for residents. Understandably, the agency's focus and resources remain primarily directed toward restoration and improvement of fundamental management services, particularly those related to ongoing maintenance, security, modernization of basic physical systems, and redevelopment of vacant units or units at high risk of vacancy.

Previously the authority's social services program consisted of traditional counseling and case work services provided centrally and, in some instances, on site. These services had limited success in improving the lives of tenants or their environment in the face of the overwhelming problems just described. As part of its

operational overhaul, the authority decided to abandon this approach to service provision.

Tenant activism helped provide the "spark" which ultimately ignited the reform movement. Supported by the court and various advocacy groups, "tenant empowerment"--sometimes collaborative and sometimes conflictive--came to be used as a means for achieving change within developments and within the agency itself. To support tenant involvement, the authority provides funds to support a city-wide tenants' organization and community organizers to assist local development task forces. Within this tradition, elder services now hinge on a partnership between the housing authority, tenant organizations, and a network of collaborating community agencies. The service "program" is not one in which PHA staff provide either direct services or information and referral. It is a system which relies on advocacy and tenant organization to increase the availability of both formal and informal services at the local level.

The authority employs a single "elder services coordinator" who is its liason to agencies which deliver services to groups or individual senior tenants in developments. In 1984, this coordinator met with representatives from eight organizations--home care agencies, private family and elder social service agencies, the local commission on the elderly, an elder advocacy group, and university medical and dental schools--and developed a plan for "increasing and strengthening coordination of services provided to elder residents". (Since then a visiting nurse agency has also joined the plan.) This new program, called the "Boston Consortium"

(Consortium for Health and Social Services to Elderly Tenants of the Boston Housing Authority) received joint funding from the BHA and other sources, both public and private..

Eighteen elderly buildings and one family development with a high percentage of elderly were selected--those already identified through a housing authority study as developments with the most inadequate social service resources, short waiting lists, and high numbers of the very low-income elders. Funding was obtained from a local foundation and from the state's Departments of Elder Affairs and Community Development. In addition the project received large amounts of in-kind services from the participating agencies and other community sources. Initial in-kind contributions included half of six social workers' salaries, fiscal management and administrative back-up, health education and screening, group classes, programs and trips, and a large corps of volunteers.

Prior to the Consortium, two of the member agencies had been involved in providing some services to elder residents, including part-time social workers in nine buildings. Under the Consortium, the primary service elements in each of nineteen buildings include: needs assessment, tenant organizations developed or strengthened, and collaboration on service provision through regular meetings of managers, tenant representatives, and social and health service representatives. The housing authority provides authorization, space and utilities and partial funding. Core staff include six on-site social workers who supervise the needs assessment (carried out by tenant volunteers) and assist the tenant organizing and community organizing. A health care coordinator works specifically with health agencies to increase on-site health care (including

acquiring equipment for in-home dental care.) In addition, volunteers (including two volunteer coordinators) from a major elder advocacy organization support the tenant organizing activities. Other staff and volunteers are provided by the university medical and dental services, home care and family service agencies, and the aging commission. An organizational chart is attached to this report as Appendix E.

As a result of this project thirty-eight other health and social service agencies now play "a significant role in providing services to housing project residents." Secondarily, tenant organizations working with the authority have been able to resolve problems such as out-of-order elevators, no heat in hallways and community rooms, plumbing in need of repair, and problems with building security. The tenant groups have also organized a wide range of activities, trips, and social events for residents.

The project is directed by an Administrative Council consisting of representatives from the nine member agencies. There are two co-directors, one from the family service agency and the other from the university home medical service. (The family service agency is the fiscal administrator.) As one director explained, however, the real consortium is not this administrative organization--it is the "'consortium' of tenants, managers, on-site staff and agencies working together at the local level." The authority's elder services coordinator said, "The unique points to the Consortium are that service providers are directly involved with tenants in identifying needs and in the planning process. Also, the tenant organizations are informal service organizations--they get people

interacting and helping each other."

Boston: Program Directions and Goals

The first goal of the Boston program is to continue raising the financial, in-kind, and volunteer resources needed to keep it going. (Some of the original grants were one-time or short-term demonstration grants.) Participants are optimistic about doing this, and feel they have a strong organization and a successful track record to help them make their case.

The longer-range goal is to expand the program to include additional developments (some already have service staff and programs independent from this one) and additional types of services. The authority's coordinator is working to bring other needed services--such as alcohol and substance abuse treatment--into the Consortium or a separate but similar organization in a systematic way.

In summary, the Boston program has involved a number of community agencies in sharing the initiative for addressing the service needs of elders in public housing, and has also involved them in helping organize and work with the tenants themselves. The approach appears to be generating services, service coordination, and tenant involvement without extensive use of PHA resources other than space and the coordinator's salary. The PHA respondent describes a sense of momentum and popular support, and feels the program may be one that other PHAs can learn from--especially those whose resources do not permit them to take a direct role in service provision. She also points out that there is "risk" involved--other agencies must be entrusted with a major role, tenants must be given real power, and funding sources must be "sold" on an unusual

idea--but feels the risk is well worthwhile.

Mobile, Alabama

The Mobile Housing Board houses slightly fewer than 3,000 elder households. About 700 of these live in four large high-rises, but over 2,000 live in family developments. (Seven developments have 40 to 60 percent of their units occupied by elderly.) Two of the elderly developments are less than ten years old but the family developments are twenty to forty years old. The overall ratio of elderly to family units is 1:5.

The great majority of elders in both the elderly and family developments are the "younger elderly"--62 to 74 years old--but they are growing older. Major problems noted on our survey in the elderly developments are residents' inability to maintain units and difficulty in obtaining alternative placements when needed. The waiting list for elder units is very small--15 at the time of our survey-- and waiting periods are only one to two months. About 20 percent of elderly units turn over annually, with the majority (70 percent) of the departing residents moving in with family or going to nursing homes. Even with a small waiting list and average turnover, the housing authority reports that vacancies are not a major problem.

Mobile: A Program of "Normalization"

The principle theme in Mobile's approach to its elderly can be summed up in one word: "normalization." By virtue of the ages and distribution of elder residents (i.e., younger and predominantly in family developments), the emphasis in both policy and service delivery is on "senior" being a normal, healthy and productive

"life stage". (Only as some current residents have begun to be moderately dependent have steps been taken to increase more fundamental support services such as homemakers and meals.) In the authority's opinion, emphasis on healthy functioning rather than dependency contributes to a positive environment for elder residents and makes public housing an attractive option in the local elder housing market.

Consistent with this emphasis on the independent elderly, Mobile's admission policy tends to exclude elders who need many supportive services. The authority's formal policy states: "The elderly and handicapped are initially housed based on their ability to live and function independently." A simple outline of independent living criteria is the basis for home visit interviews (see Appendix F). If there is any question, staff from the PHA's Department of Community Services make a more complete assessment and a recommendation for or against occupancy. As part of the application process, names of <u>two</u> sponsors are obtained. (Many authorities require one.) These are family members or friends who will be responsible for working with the authority to make alternative placements should the elder become dependent.

Occupancy policy regarding current residents is more flexible and lenient than admissions policy. (This distinction is also consistent with a "life stage" philosophy of aging). Current tenants may remain if they need "minimal services. . . . even if they must rely on PHA staff to arrange for these services." The housing authority refers to this in its policy as "partial dependency"--that which can be adequately supported with homemaker ser-

vices and meals. The housing authority takes an active role in arranging and providing these services, following referral of elders (by managers, other tenants, or other agencies). Referrals are passed on to the social work staff in the Department of Community Services for assessment and development of "plans of action." The authority states, "Practically all of our cases are resolved at this point. Many live out their years with the homemaker assistance."

However, for those elders whose level of need becomes greater, the authority has specific and well-developed procedures outlining the steps which staff will follow with the resident, family, sponsors, health and social service agencies, and, if necessary, the court in order to obtain a higher level of care in a different setting. (Appendix G describes these procedures in detail.)

In short, the Mobile Housing Board's elder population is, in general, smaller, younger, and healthier than is found in the majority of our examples. Given this population, the authority's policies and practices emphasize what might be called "enrichment" services for the majority, and a moderate level of supportive services to prolong as long as is feasible the independence of those growing frail. When transition to a higher level of care is necessary, attention is given to making the transition as smooth as possible for the elder resident.

The centerpiece and main element in this approach is the multi-purpose center of the Senior Citizens Services, Inc.--a county-wide agency housed at Mobile's largest elderly development. Here, services are provided not only to all of the housing authority's elders but also to elders throughout the county--another way

of "normalizing" public housing residents by serving them in a mix of persons from other areas and other income brackets.

The housing authority's Community Services staff acquaint all new elder residents with the services provided through this center: hot lunches five days per week; arts, crafts, and ceramics; exercise (including aquatics, dance and music programs); social work and counseling; information and referral; chapel services and Bible classes; a library program; and an array of trips and social events (for a sample monthly calendar, see Appendix H). A widespread transportation program links the other elderly developments with the center and also provides shopping trips and transportation to medical appointments, other nutrition sites (described below), and volunteer assignments. A social worker from the center regularly goes to the other major elderly developments to provide on-site services.

A Retired Senior Volunteer Program (part of the federal ACTION program) operates through the center, allowing elder residents to volunteer for work in sixty-eight community agencies, from museums and libraries to children's homes and youth crisis centers. The Hire an Older Worker Program provides job counseling and placement to those looking for paid employment.

Health screening and other medical services are provided at the center by nursing students from the University of South Alabama. (The university also places students from its recreation and leisure services program here.) An intern from the university's medical center lives in each tower building to provide weekend and evening emergency call service. The center and its outreach ser-

vices are supported by funding, in-kind donations, and volunteers from the United Way, state, county, and local government agencies, businesses, academic institutions, and the Mobile Housing Board.

Additional community agencies are also involved in serving residents, however. The SAIL Program (Senior Activities for Independent Living), a program of the regional planning commission which carries out area-wide need assessment and planning for the elderly, provides a hot lunch and social/recreational services program at four sites near the authority, in space donated by churches. Transportation to these sites is provided by "maxi-wagons" from the senior multi-purpose center.

For the more dependent elderly, those with mobility problems or needing assistance with homemaking and person care, the Senior Companion Program of Mobile County and a Meals-on-Wheels program provide visitors and in-home meals. However, authority social services staff believe that these services are not fully meeting the need for them.

The most important element in serving this frailer population is the housing authority's own homemaker service. Funded through a contract with the state's Department of Human Resources with additional assistance from the United Methodist Inner City Mission, this program recruits and trains homemakers from among the authority's own residents--thereby providing employment assistance as well. Services provided to elders include personal care, housekeeping, and some meal preparation. The homemaker program currently serves approximately 150 residents, "for a few hours each week"--varying with the level of need.

Mobile: Program Directions and Goals

It is the board's position that the array of services just described serves the current population of elder residents adequately and accords with the authority's goals of independence and "normalization." This wide availability of services which provide enrichment and modest assistance, supported by a large number of community organizations and funding sources, may offer a model for those authorities whose own demographics and environment are similar to Mobile's.

However, both management and social services respondents to our survey in Mobile noted that a growing number of elder residents are experiencing difficulties in maintaining their units adequately; growing numbers also need additional homemaker, health, and case management services. These indicate a gradual rise in the average ages of current residents. If long-term institutional care also becomes scarcer--as seems likely in most parts of the country--the authority may soon find itself pressed to provide or to facilitate services for a more dependent elder population.

5.4 Smaller Scale, More Informal Programs

Most housing authorities in our survey have not developed comprehensive systems like those described in Section 5.3. Many others have less fully rounded approaches that merit serious consideration, however. This section discusses five such programs, more briefly than those described earlier.

These are not PHAs which have decided to offer no supportive services to extend independent living for their elder residents. They are PHAs with the same three basic characteristics as those

discussed earlier. That is, (1) they have defined procedures for assessing independent living capabilities, based on some professionally determined standards. These procedures may involve fewer people in decisions than is the case in "comprehensive" programs, or they may be applied informally rather than uniformly. (2) Either by job description or by accepted custom, PHA staff are expected to work with individual elder residents to avoid inappropriate evictions and premature institutionalization. (3) The authorities are working actively and creatively to obtain the level of supportive services they have determined to be appropriate from a range of community sources.

In contrast to PHAs with "comprehensive" approaches, policies and procedures may be less systematic and less consistently applied authority-wide; service offerings may be less varied or simply smaller in scale. This may reflect an earlier stage of program development, fewer financial or personnel resources, a different clientele or political environment, different availability of services within the community, or simply varying decisions about strategy and priorities. Again, our descriptions are based on relatively brief conversations with PHA administrators and staff and whatever written materials have been sent us. They are as accurate as we have been able to make them under those conditions, and as complete as very limited space permits. They are intended only as "pointers" to help other PHAs identify programs they may want to contact directly and learn more about.

St. Paul, Minnesota

Slightly over 2,500 elder households live in 16 "high-

rise communities," and about 100 more in family developments. Elderly units outnumber family units by a ratio of 3:2. Almost 40 percent of the elderly are between 65 and 75 years old, and 41 percent are between 75 and 85. Fourteen percent are over 85. About 500 households are on the waiting list, and waits vary from zero to twenty-four months depending upon unit size needed (one-bedroom being most in demand).

St. Paul: Occupancy Policy

Applicants may be offered units if they need minimal services . . . and can arrange for this assistance. Current tenants may remain even if they need ongoing assistance, if services are available and are accepted by the resident.

St. Paul: Assessment

Like several other PHAs we have discussed, St. Paul uses a highly developed and formal set of assessment procedures for applicants as well as current residents. Assessment guidelines enumerate twenty "routine living skills," half designated as "critical" and half as "contributory". Level of functioning is also rated on a scale of three: independent, independent with supportive services, and alternative living situation required.

Instructions stress that these are guidelines only, and that occupancy decisions about current residents will be made in the context of casework and a case conference involving PHA representatives, service providers, tenant, family members, and sponsors. However, "critical factors relate directly to lease requirements and immediate health and safety conditions. If a resident's skill level in any of these critical factors falls within the category

requiring an alternative living situation, management and social service personnel should take this as sufficient reason to move for a prompt placement . . . in a more suitable situation."

These criteria also provide the basis for in-home interviews of new applicants, often conducted by one person from the PHA's human services staff. Such an interview takes place if occupancy staff develop reservations about the applicant in the course of the application process. In contrast to current residents, with whom the PHA plays a role in obtaining services, an assessment that services are needed by applicants leads to another formally defined procedure for assuring that services are in place and will "move" with the applicant.

This procedure is the enactment of Sponsor Statements. The tenant, the sponsor--frequently an agency representative--and PHA management and services staff execute a signed agreement enumerating (1) the "service needs that must be addressed by the sponsor", (2) the applicant's agreement to receive such services as a condition of the lease, and (3) agreement to updating of these conditions "as the need arises." [3]

In its introduction to these materials the housing authority makes a concise statement of its goals, in which one can see clearly the linkage of management and service concerns. First is the recognition that the PHA has a responsibility to "assist the

---

[3] Sample pages from the independent living guidelines and from the procedures for obtaining sponsor statements are attached to this report as Appendices I and J, respectively. For more complete information, contact the Public Housing Agency of the City of St. Paul, 339 Bremer Building, 419 North Robert St., St. Paul, MN 55101. Tel. 612-298-4487.

individual resident in maintaining his/her personal health, happiness and welfare"; and secondly that it has a responsibility to "insure the health and safety of the hi-rise community as a whole." "The establishment and judicious employment of some norms of hi-rise living skills enhance the PHA's ability to maintain safe and decent housing conditions and make effective and efficient use of available human service resources."

St. Paul: Service Delivery

The housing authority maintains a staff of Human Service Coordinators who receive referrals from "caretakers" who live in each building, other management staff, tenants, and other agency personnel. For example, a referral may be made by a manager after inspecting a tenants' unit. Human Service Coordinators conduct assessments as described above and help tenants arrange for needed services.

The authority has a small contract with a local family service agency for limited counseling and other forms of social work intervention. The coordinators also have a strong network of informal relationships with the county human services department through which they can make referrals for visiting nurses and health aides, chore assistance, assistance with financial entitlements, and the help of an adult protection unit. Informal arrangements with Catholic Charities provide similar services.

The housing authority has two "supported living" programs. The Congregate Housing Services Program, federally funded, serves 50 of the 220 elder residents of one of the high-rises with congregate meals (2 per day, 7 days per week), housekeeping and personal

care, 24-hour emergency assistance, and counseling. Participants also pay for these services on a sliding scale.

This program has attracted additional services to the building, such as a three-day-per-week day care program, a weekly medical clinic for health screening, and an Alcoholics Anonymous group. These services are funded and staffed by the agencies that run them. The housing authority respondent noted that the congregate program has brought many services into the building that non-CHSP participants utilize (such as the meals and the nursing clinic) and that many residents, once resistent to the program because of its "nursing home" connotations, now enjoy the "healthy activity and interaction" that it has brought about in the building.

Finally, the authority, with the county human services department, has just initiated a unique "program for hearing-impaired people with mental or emotional disabilities." The authority will provide ten specially adapted units and office space, utilities, maintenance, and management services, plus a liaison staff person. The county agency will provide the full range of supportive and training services required to "develop a greater degree of independence" on the part of the participants, who will be eligible PHA applicants or current residents. Each agency will screen applicants, and the program will establish a community advisory committee to provide input and oversight. Fees for services will be based on participants' ability to pay.

In summary, the St. Paul program is one which places priority on the service needs of current residents. It uses a systematic assessment procedure and obtains services through a combination of small-scale contracts with providers and an informal network in

which designated PHA staff participate.

High Point, North Carolina

Of High Point's approximately 500 elder households, 63 percent live in three elderly high-rises and the remainder are dispersed among the family developments. Many more of the "older elderly" live in the elderly developments, but otherwise the percentages in each age range are similar to St. Paul's. The overall ratio of elderly to family units is 1:3. Twenty-three are on the waiting list and the average wait is six months.

High Point: Occupancy Policies

Formal eligibility policies for both admission and continuation state that the elder must be, "if single,... capable of living independently," and this is reiterated in our survey responses. However, the survey further notes--referencing the response to a clause in the actual lease--that current tenants may remain as long as they are able "to provide temporary or permanent assistance as needed for adequate self care . . . ." The survey then noted that assistance in obtaining services is provided by managers and tenant services staff in some developments.

High Point:Assessment

All elder (and handicapped) applicants are visited and interviewed by the manager of the three elderly high-rises. The interview is based upon a simple need assessment form which enumerates "Seven Activities of Daily Living", some general social-emotional factors, health problems and related information, emergency contacts, and agencies or persons currently providing assis-

tance (see Appendix K). In practice, applicants may be accepted "if they have the services needed to make up for their own limitations--that is, assisted independence."

Current residents of the high-rises who need assistance receive some help from Resident Aides, PHA staff who are assigned to each of the three elderly buildings. With their help the manager also monitors the condition of residents in those buildings and receives referrals of problems from both tenants, managers of other buildings, and outside agency staff.

A Professional Assessment Committee screens current residents of any building who are referred for possible transfer to a CHSP program in one of the elderly buildings. The committee is made up of the manager of the elderly developments and representatives of the agencies which provide services to the program. The screening is based on a somewhat longer--but still distinctly "friendly"--form which inquires into ability to care for one's apartment, look one's best, "keep busy," and other medical/physical/social problems (see Appendix L). Residents who are found to need the program are wait-listed for transfer into it as vacancies arise. Those who need interim or other services are helped in obtaining them with referrals by the manager.

High Point: Service Delivery

As noted above, the three elderly high-rises have PHA Resident Aides on-site, who help tenants with simple tasks and chores, provide companionship, and help identify needs or problems.

A federally-funded congregate meals program provides a noon meal five days a week to all elders in the community at two of the

elderly buildings, and transportation to it as well as related services have been obtained from the Council on Aging and community volunteers (including other PHA residents).

This program actually operates for four hours each day, and in addition to the meals provides nutrition information, information about elder services in the community, organized games, activities and outings, shopping trips, exercise, arts and crafts, service groups, Bible study, and special celebrations (for example, birthdays and holidays).

The Congregate Housing Services Program is available in addition to the congregate meals program in one of those buildings, serving 23 residents out of an overall building population of 105 with two meals per day, 7 days per week. (The congregate meals program serves 25 additional residents.) One meal is a "bag supper", delivered to be eaten as-is or heated up. As there is community space on each floor, staff help organize "lobby meals"--especially for those who have difficulty getting to the dining room or are inclined to be isolated--where three or four residents on one floor have their meal together. Meals are provided to the most frail and elderly residents of the building.

Additional services include housekeeping and chore assistance, daily if needed; help with personal care, errands, and mail; counseling, and information and referral, plus the services related to the meals program itself. Fees are charged on a sliding scale for some services to supplement the federal funding, but the range of services available is also based upon in-kind support (volunteers, social workers and nurses) from the Council of Aging, a hospital,

the Department of Public Health, and the Department of Social Services. Federal funding and client fees cover the costs of the two "service aides" specifically assigned to provide housekeeping and chore services to participants in this program.

As in St. Paul, the presence of this program and its tie-in to other agencies and services has brought increased opportunities to all the building residents. Moreover the Council on Aging's transportation component, the heavy use of volunteers, and a major emphasis on outreach to families of participants in both the congregate living and congregate meals programs has opened up new avenues of support and awareness in the community.

The hallmarks of this authority's approach are well-thought-out assessment procedures, a widespread though largely informal referral process using PHA staff in a network of community agencies, and a very successful "piggy-backing" of community resources with the PHA's own limited resources to achieve maximum access to services for residents.

The PHA respondent cited two specific needs for future program development:

(1) The information and referral role needs to be strengthened by further policy which clarifies the role of other managers in the process; at the present time it varies according to individual managers' awareness.

(2) "We are desperately seeking additional funds to continue and expand the CHSP program--we are so sold on its effectiveness."

Knoxville, Tennessee

Nearly 1,300 elder households live in five elderly de-

velopments of approximately equal size and age (240-270 units, 16 - 19 years old but one 10 years old). Only two hundred and sixty live in family developments and no family developments have a high percentage of elders. Information on the ages of elder residents is unavailable. The overall ratio of elderly to family units is approximately 2:5. The waiting list contains approximately 80 households, and waits are from zero to eight months depending upon unit size.

Knoxville: Occupancy Policies

According to the survey responses and the lease agreement, formal policy states that applicants may be offered units and current residents continue to occupy units as long as they need only minimal services and can arrange for this assistance without PHA involvement. In practice, the agency has site managers and tenant services staff with gerontology training at the central level,and also has two programs specifically targeted to the elderly (see below). These resources have moved progressively in the direction of systematic assessment and service provision, and agency staff now play a role in assisting current residents to prolong their occupancy with supportive services.

Knoxville: Assessment

There is no systematic screening of applicants by the agency comparable to the standardized questionnaires or measures described in some previous examples. However, occupancy staff do ask general questions about the applicant's ability to manage personal care, apartment upkeep, financial arrangements, medical needs, and so forth. In addition they inquire about other agencies

already involved with the applicant and "work closely with those workers" to determine services needed or in place before occupancy decisions are made. In a number of cases, "workers from other agencies--such as the state's Department of Human Services--make the appointment and bring the applicant in." These workers, as well as the housing agency's elder services staff, frequently sit on or have recourse to Geriatric Screening Teams established by the other agencies. If there is a question about an applicant's abilities or needs, more thorough assessment can be provided by one of these teams.

Knoxville's public housing agency, recognizing "the special needs of people living in public housing," enlarged its goals and components several years ago to become, officially, "Knoxville's Community Development Corporation." This corporation manages both housing and a variety of social service programs. References to tenant services staff and elder services staff are to the workers and programs under the corporation's Human Resources Department (HRD), targeted to residents of public housing units.

Current residents identified by managers or outside agencies and referred to the elder services specialists are also assessed by a Geriatric Screening Team, either under the auspices of the referring agency or a team in which the Human Resources Department staff person participates. The information obtained through the assessment is used in a variety of ways. HRD staff work with site managers, tenants and families to locate and obtain services from community agencies, and may provide short-term direct counseling to the elder tenants and their families. Finally, HRD staff may refer

elder residents to one of the agency's own programs where more intensive service plans are developed and delivered (see below).

Knoxville: Service Delivery

Specific elder service programs provided by the Human Resources Department include Community Services, Transportation, Adult Day Care, and Adult Protective Services.

Community Services consist of social, recreational, educational, and crime prevention programs. In each of the elderly developments there is a full-time recreational worker who provides group activities. Two social workers also provide more direct counseling and individual case management.

Mini-buses owned and operated by the agency are the basis of a transportation system available to all housing residents for trips to medical facilities, other community resource agencies, and the agency's day care programs (the Human Resources Department also operates four child care programs).

Adult Day Care is provided at the Daily Living Center. A social worker, activities specialist, and volunteers provide "activities which enhance daily living skills, social interaction, and health maintenance" to any income-eligible Knoxville residents who are 60 or over and are referred through the Human Resources Department. Individual plans of care vary from one to five days of attendance per week and include screening and assessments; counseling services; health monitoring; education; coordination with health care facilities; meals, snacks, and nutrition information; and group work related to fitness and activities of daily living.

The Human Resources Department is authorized by the Tennessee

Department of Human Services to maintain an Adult Protective Services unit which provides counseling services to elders who are abused, neglected, or exploited. Two social workers assigned to this program take part in assessments, provide counseling and transportation/escort services, and arrange referrals to the adult day care program or community health and home care agencies.

Funding for the Human Resources Department comes from PHA operating funds and from state and federal programs for community development and social services. In particular the Tennessee Department of Human Services is a partner and conduit of funding for many services.

Two additional housing authorities deserve inclusion in this category, but will be described in even less detail because of their basic similarities to those described above. Their particular programs do include, however, some additional alternatives for assessment and service delivery which may suggest useful directions for other housing authorities.

Chattanooga, Tennessee

Chattanooga houses approximately 1,400 elder households, about half in three medium-size elderly developments (with six buildings) and half in several family developments with very large concentrations of elders. The waiting list is very small and the waiting period zero to two months for most units. Occupancy policy for both applicants and current residents is to accommodate even those who need ongoing assistance as long as this assistance can be

arranged without involvement of PHA staff. As in many previous examples, however, the authority provides access for current residents to a program which arranges such assistance.

Specifically, the housing authority gives space in one elderly development for a private family service agency to provide an Elder Outreach Program. Supported by the United Way and other grants, the program serves elders in all elderly and family developments who are referred by development managers or others. Social workers make home visits, do assessments, provide counseling to elders and their families, and help arrange for needed services. When necessary they provide ongoing counseling and case management. (A new program is also under development through which the family service agency, in formal partnership with several community elder service agencies, will provide comprehensive case management services from a center housed in PHA space. The program was not funded on its first try, but efforts are under way to achieve its goals in some form.)

An agency called Senior Neighbors operates two "full service centers"--nutritional, social and health services--in two elderly developments and congregate meals plus recreational services at two other sites. (As in previous examples, such programs help generate additional services and resident participation).

A "buddy check" system has nearly one hundred percent participation by the residents in the elderly buildings. Similar to the "I'm O.K." program in Minneapolis described in Section 5.3, volunteers organized by the Resident Organization monitor cards put out on doorknobs in the morning, follow up with calls if cards are not put out, and contact the manager if there is no response.

Finally, the authority gave one unit--and helped convert it--to a resident-operated beauty parlor, which has become a popular and important center of activity in its own right.

Greensboro, North Carolina

Greensboro houses slightly fewer than 900 elder households, roughly half in four small and medium-size elderly developments and half concentrated in a handfull of very old family developments. The waiting list is large (over 100) for the number of units available and waiting periods are over one year. Applicants are accepted if they and a family member sign a written agreement that they are capable of independent living or will accept support services if need for them exists or arises. (See below.) The authority has made provision for assessment and service delivery for current residents which permits flexiblity and tolerance toward those who need ongoing services, up to the point of being nearly bedridden, having serious medical problems, or behavioral problems unamenable to the treatment available. (Only 6 percent of elderly units are vacated annually).

Like High Point, North Carolina (described previously in this section), Greensboro's elder services system is able to operate with one manager as its focal point because of the relatively small number of elder residents. Nevertheless the same three essential elements exist as in the larger programs, and for small authorities this manager-centered model appears to be highly workable.

Specifically, the housing authority has an "informal good faith agreement" with a county mental health program. This program provides a range of mental health services, including a walk-in

clinic, at no cost or on a sliding scale to all county residents. The manager of the four elderly buildings has a long-standing relationship with this program through which she can arrange assessments and consultations on current residents, if problems with independent living seem to be in evidence. Because the program is independent of the authority and available to all residents of the community, applicants can be referred as well as current residents. On the basis of that assessment, lease agreements can then stipulate services which must be in place and accepted by applicants before they are offered units. (Mental health staff provide counseling and assistance in arranging these services.)

For current residents, agreement is reached on the counseling which the mental health agency will provide, and the PHA manager arranges other services--e.g. homemaker-chore services, transportation, meals, health aides and visiting nurses. She is able to do this in part under a written agreement between the housing authority and the local public health department.

Finally, under another written agreement with the Geriatrics Department of the University of North Carolina School of Nursing, nursing students do field work in the two largest elderly developments, at least weekly. In a clinic room or during home visits they provide blood pressure testing and other forms of medical monitoring, nutrition and health education, medical referrals, and simple companionship.

5.5 Examples of Program Components

The two previous sections have discussed programs as a whole. This section concludes the chapter by presenting additional ex-

amples of program components. In most cases, these components are not the only program offered by the authority, but are part of a larger package. They have been selected for inclusion here because each adds something to our knowledge of the varying ways in which services can be provided or organized.

Home Care, Personal Care Programs

Columbia, South Carolina: "Institutional Avoidance Program"

Three PHA residents, AFDC mothers, are trained at a local hospital to provide homemaker/home health aide services to the authority's elders. They serve 30 to 40 of the 750 elder residents at any given time with cleaning, shopping, help with medications, and "simple TLC, that's key." The program also pays for a part-time nurse who assesses elders' needs on referral, provides referrals to health and social services, offers health information classes, and organizes an annual health fair called "How's Your Health?" for residents, staff, and the community at large. The health fair also involves volunteer doctors and nurses from the community. The nurse schedules the aides, whose time with clients ranges from one day per week to daily, one or two hours per day.

The program was begun as a demonstration with state funding. When that ended, the Columbia Housing Authority continued the program with its own funds. Transportation for the nurse and aides is provided by a PHA van funded by the state.

Said the PHA respondent, " The big problem is usually abandonment by elders' [family or other] sponsors, but these are usually simple cases, simply solved. The staff are saints. We've

had a good return on our investment. In ten years we've only had to institutionalize ten people--when we simply couldn't sustain a reasonable environment."

Rochester, New York: "Extended Shared Aide Service"

A local agency which is the clearinghouse and coordinator for nursing home placements throughout Rochester has contracted with a local home health agency to provide this service with government funds and some private support. There is no cost to Medicaid recipients who are participants or to the PHA. The program provides around-the-clock service--one aide per eight-hour shift--to a small group of elders who live in the same building. The clients are all "almost bedridden". Services include meals, shopping, chores, personal care, and emergency response. Visiting nurses from the same agency can also be called in as needed. This is a new program, and plans are under way to expand it to several additional buildings during the coming year.

Cambridge, Massachusetts: Coordinated Home Care

The Cambridge Housing Authority has worked with the primary home care agency operating in its developments to assign all the elder clients in a given building to a single case manager and to the same personnel--e.g., homemakers, health aides, and nurses. The authority's tenant services staff, together with the provider agency staff, can then coordinate referrals, share information, and do joint planning for a client or a building. This also helps the building's residents become more familiar with service providers, avoiding confusion about whom to contact with problems or questions.

Health Care

Milwaukee, Wisconsin: "Wellness Clinics"

The housing authority provides free space in all elderly developments--13 high-rise buildings housing over 1,800 elders--for three university nursing schools to provide basic health services to residents. The program began when one school proposed to the PHA that some of the elderly developments become intern sites for students. Newspaper coverage of the program led to the other two schools' following suit.

Agreements between the PHA and the schools call for Masters' level nursing students to be on-site for amounts of time which vary with building size. Services include preliminary physical examinations, medical and social service information and referral, counseling, exercise classes, help with mobility problems, diet and nutrition classes and assistance, and vision and blood pressure screening. The program serves about one-third of the elder population on a "semi-regular basis". (Note that similar programs also exist in Minneapolis and Greensboro; all use volunteer services from medical and nursing students under agreements with local educational institutions.)

The PHA pays only for space and utilities for the clinics. However, its operating budget also provides a community services staff--social workers and paraprofessionals--who take referrals from and make referrals to the program. They help with assessments, obtaining home care and related services, and offer counseling for residents and their families. The PHA respondent said, "The costs are well worth it from a management standpoint."

Chicago, Illinois: On-site Clinics

Under agreements with a number of the city's major hospitals, fully trained doctors and nurses, geriatrics specialists, provide services at 19 of the authority's 53 elderly developments. The PHA makes space available free or at low cost. Locations are chosen to be near participating hospitals and also to provide access to elders living in other developments.

Hours and available services vary across sites. In some cases, transportation is offered to the participating hospital for services not available on-site. Medical services include physical examinations; help with medications; diet and exercise classes as well as individual help with nutrition and mobility; vision and blood pressure screening; and podiatry. Most sites also have staff who provide counseling, information and referral, and social and recreational programs.

Funding for medical services is largely through Medicare, with hospitals absorbing other costs. The hospitals' incentive is the recent implementation of DRGs for Medicare reimbursement. They feel that it is "both cost effective and health effective" to provide preventive and supportive services on an outpatient basis, given the economies of scale involved--i.e., large numbers of elders in developments scattered throughout the city.

Omaha, Nebraska: On-site Clinics

Omaha exchanges free clinic space for basic "health maintenance" services from a local home health agency in all 12 of its elderly developments. Under an agreement between the PHA and the agency, registered nurses staff on-site clinics for several hours a

day, two to three days per week, depending on the size of the building. Services are free to residents.

The nurses provide medical screening, help with medications, information and referral, health education,and other services. They are also able to offer some services that require a physician's orders and supervision, thus saving residents trips to physicians' offices.

Congregate, Sheltered, and Enriched Housing

The terms "congregate", "sheltered", and "enriched" housing usually refer to similar programs--those which combine housing with some supportive services such as congregate meals, home care, and/or case management. Terminology varies among PHAs with level of services provided, funding sources, and governing regulations.

The federal Congregate Housing Services Program (CHSP) provides demonstration funds to participating PHAs for congregate meals and a limited level of other services. Typically, elders remain in their normal apartments and some space in the building is converted for preparing and serving cooperative meals, program administration, and provision of any additional services. Professional Advisory Committees (PACs), with representatives from the PHA and any provider agencies, are established to screen applicants and oversee program management.

Some states, such as New York and Massachusetts, and many individual housing authorities have also developed programs which either supplement CHSP or provide similar facilities, with greater PHA autonomy over design and frequently with a higher level of care. In Massachusetts, for example, an aggressive state program

for building or rehabilitating congregate facilities is under way. These facilities are usually designed with more shared spaces--e.g., kitchens, sitting rooms, or bathrooms--and thus place more emphasis on cooperative living than normal elderly housing, including CHSP programs. The state's housing and elder services agencies develop interagency agreements at an early point in the approval process to assure that state-funded services will be available to each state-funded congregate facility.

Programs in Baltimore, Minneapolis, St. Paul, and High Point have been discussed earlier in this chapter. The two programs below are both funded by Medicare and the New York Department of Social Services. Both are "quasi life-care" programs. That is, residents turn over almost all their income--primarily SSI--to the program and receive back $28 per month for personal spending money. All other services are provided: rent, utilities, telephone, all meals, home care and personal care, shopping, financial management, counseling, recreational services, and emergency response. These programs stop short of providing medical services but can help residents obtain home health aides and nursing care. As a result, they often are able to provide supported living up to the point that skilled nursing home care is needed.

Syracuse, New York: Enriched Housing

The PHA used its own resources and some from the state to convert two adjoining units in a large elderly development into living, dining, kitchen, and office areas. The 30 participants (15 at each site) retain their own self-contained apartments anywhere in the building, though some also transfer in from other buildings

or from the outside community. The authority gives space to the service provider agency, a nonprofit entity created by a local for-profit skilled nursing home. This agency is called Enriched Resources for Independent Elderly (ERIE) and has its own board of directors. It provides the program director--who manages the staff, equipment, supplies, and day-to-day operations--and an on-site social worker, a cook, and a home health aide. The PHA's Coordinator of Community Services acts as liason for the authority, facilitating referrals and helping obtain other services or counseling.

Referrals to the program are made by PHA Community Services staff or neighbors, as well as by self-referral. Elders who are not PHA residents may also be referred by outside agencies. The waiting list is one to three people at any given time; priority is given to current residents of PHA housing.

Whenever possible, residents help staff plan, shop for, and prepare meals--a hot congregate meal at noon and food available for light breakfasts and suppers which can be eaten in individual units or in informal groups in the dining area. Other supportive services include homemaking and personal care, help with individual shopping and medical appointments, help with financial management, discussion groups and social activities, counseling, information and referral, and crisis intervention.

The PHA respondent said that the program "took a long time to get off the ground". Current PHA residents are particularly reluctant to switch over to a system under which they pay so much of their income into the program, but often agree if they realize that

their only other option is institutional placement. Elders new to public housing tend to accept the program more readily.

Rochester, New York: Enriched Housing

Rochester's Enriched Housing program is nearly identical to that of Syracuse, except that the lead agency is a local family service agency rather than a nursing home. The program operates in two buildings, serving 28 out of 100 residents in one and 15 out of 30 in the other. A third building in which 40 out of 318 residents would be served is currently under consideration. If no PHA applicants are on the waiting list, the family service agency places income-eligible applicants from a community-wide waiting list.

Two prepared communal meals and a substantial snack to eat at home are provided five days a week. Weekend meals are simpler, largely pre-made so they can be eaten at home. (Most residents eat together in the common dining areas anyway.) By coincidence, the director is a registered nurse and is able to provide some medical services and referrals. Direct telephone lines connect residents with a centralized emergency response system, staffed 24 hours per day. Other services are similar to those in Syracuse.

As in Syracuse, the PHA respondent says that residents are reluctant at first to turn over most of their income to the program but accept it positively after they learn what it is like. The respondent adds, "We're doing everything possible to expand this program. It stretches the time before nursing home placement becomes necessary and greatly reduces our problem with vacancies."

Security, Communications, and Use of Volunteers

This section describes a variety of programs that are carried out by community volunteers or by elder residents themselves, on a volunteer basis or for a small stipend.

Cambridge, Massachusetts: "Neighborhood Watch"

The Cambridge Housing Authority has recruited elder residents in twelve of its elderly developments to participate in a crime watch program. They sit shifts at the entrance to each building from late afternoon until as late as 1:00 or 2:00 A.M., and have direct hotlines to report any trouble or suspicious activity to the nearest police station. Participants are paid a monthly stipend of $25, but are considered volunteers since they often work 20 to 30 hours a week. (The stipends do not depend on how much time is contributed, but are lowered somewhat for participants who spend significantly less time than average expectations.) Funding is from the PHA's operating budget.

Residents are recruited through door-to-door flyers, resident organizations, and other agencies active in the buildings. If few volunteers are forthcoming, the PHA says it is "often a sign of a depressed building," one which may need other basic services. In most buildings participation is a social activity. All volunteers are accepted "unless they're going to be a real problem. Then we try not to say 'No' outright but put them on a list of alternates or back-ups."

Local police provide several days of training. ("Mainly, 'Don't intervene', but also some information on narcotics, making identifications, and other security-related subjects.") A special certificate is presented in a graduation ceremony. A coordinator

makes up schedules which can vary with individual needs and interests. An average shift is two hours, but some prefer to stay longer.

A large building (300 units) can be covered well with 28 to 30 volunteers, the PHA reports. "In smaller buildings we cover what we can." The respondent stressed that the program only works in buildings with limited access--one main door--and would not work in large family developments or other situations with many entrances. The PHA feels that the program primarily provides an increased sense of security for all residents. "It has stopped some crime and vandalism, but these are not high crime areas. If there were a real safety problem in the neighborhood, the program would not be adequate or even safe for the participants."

Oakland, California: "Dial-A-Care"

Five elderly volunteers, paid small stipends with joint funding from the housing authority and the Older Americans Act, work five days a week from 8:00 A.M. until noon, calling elderly or disabled people who have enrolled for this free service. (A sixth volunteer has been obtained from the Retired Senior Volunteer Program--RSVP--which only reimburses her transportation costs.) This service is available to elderly or disabled Oakland residents and is provided to approximately 350, 50 percent of whom are PHA residents. The housing authority pays for telephones and telephone services.

The nature of the call is determined by the needs and wishes of the enrollee--a general "how are you?", a reminder about medicines or a doctor's appointment, information about services or activities in the community, or a conversation about the weather or grand-

children. In addition to providing outreach to the lonely and isolated, the program also attempts to ensure that someone in real trouble will be noticed and helped quickly.

Charlotte, North Carolina: "Quality Circles" and A Dance Band

The housing authority has a very active residents' organization in its six elderly high-rise buildings. The organization runs social activities and monitors service delivery. The authority's head of management, together with site managers and resident leaders, appoints a "floor leader" on each floor of a building--"those who are most agile and interested." These floor leaders then participate in a "Quality Circle", together with the building manager, maintenance foreman, and housekeeper in each building.

Each circle meets monthly with the head of management to review housing services in the building, any unmet service needs, activities which the residents would like to help organize--e.g., field trips, community gardens--and even housing authority policies which affect residents. The floor captains report to the residents' organization and also monitor and help other residents on their floors. Among other things, they arrange for celebration of birthdays or other special occasions, check daily on people' well-being, and make sure that everyone is accounted for during fire drills.

A small group of elderly and handicapped people from PHA housing and from the outside community has also formed a volunteer dance band. The band provides music for community dances, now held three weeks out of every four. The dances rotate between community spaces in all six elderly buildings, and there is great competition

between buildings for "Best Food" and "Best Decorations" awards. "These are big and popular events," says the PHA. "About 60 people from the surrounding neighborhoods usually attend, and everyone dresses up for the occasion."

Little Rock, Arkansas: Church Volunteer Program and Buddy System

The Little Rock Housing Authority has three elderly high-rises with a total of about 600 residents. An outside organization called Senior Citizens' Activities Today, using office space in one building, organizes social activities and provides information and referral for all three high-rises. When residents began experiencing severe problems in obtaining fundamental support services because of funding cutbacks, informal contacts between the authority, the activities program, and local ministers led to the creation of an organized church volunteer program.

When an elder resident needs a particular type of assistance, the building manager contacts the activities director, who contacts the resident's church. If the resident has no regular church, the closest church--which is also the largest and has a regular outreach ministry--is contacted. The activities director and the church volunteer visit the resident together and work out a regular schedule for visits, running errands, shopping, help with meals, or simple chores. The PHA respondent said, "The program has been especially crucial to residents who are returning from the hospital and still have a long road to recovery. Also, many of the volunteers are elderly themselves, and this is a nice way of drawing the community together."

The activities directors in each building have also organized a

"fairly informal" buddy system. Residents are appointed to provide a daily door-check of their neighbors, as well as to offer simple forms of assistance.

Houston, Texas: "Project HEART"

The Houston Committee for Private Sector Initiatives and the housing authority have jointly developed a project called "Help Elderly Achieve Real Ties" (HEART), somewhat like the "Adopt a High-Rise" project in Minneapolis. Three major local companies have each "adopted" an elderly high-rise to "improve the quality of life and raise the morale of the residents." Corporate volunteers, including top executives, plan and carry out social and recreational activities such as parties, shopping and field trips, movies, game nights, telephone reassurance, and one-to-one visits. The corporations have also donated new recreational equipment. The PHA reports that residents are participating in the activities in growing numbers. "The program makes our residents feel 'special' because employees work all day and then come out on their own time to be with them--not because they have to but because they want to be there."

Nashville, Tennessee: "Volunteers In Public Service (VIPS)"

Nashville's Metropolitan Development and Housing Agency began the VIPS program in the late '70s. They found that funding cutbacks for PHA and community social services were creating rising demands for their social workers. The program uses resident volunteers, elderly and nonelderly, to provide supportive services to elder residents. These services now include companionship in person or by telephone, shopping and errands, escort to medical and

other appointments, and meal-preparation or delivery.

Volunteers are recruited actively ("Be a Thum-Buddy Volunteer") and must apply in writing. They are trained on issues of aging and on housing authority policies and organization. Social work staff make job assignments, supervise, and keep records of job performance and hours worked. The only payment is certificates and awards given at an annual reception. Many of the original volunteers have grown older and have recently "retired" from the program, but the PHA reports that the response to efforts to recruit others has been beyond their expectations. There are currently 38 volunteers.

The program has helped the PHA carry out need assessments among its approximately 3,000 elderly and handicapped residents. The most severe problems were with loneliness; inability to shop, do errands, or get to medical appointments; and nutrition. Since the program began, over 15,000 hours of service have been provided, at a value estimated by the PHA at over $60,000. The PHA also sees less tangible benefits. "[The] program has served to foster stronger and more positive bonds between the resident volunteers and the agency staff. They begin to feel a part of a total team. And the agency is seen by tenants as caring for the well-being and the 'whole person' of its residents."

5.6 Conclusion

This chapter has described PHA programs to help residents obtain supportive services. Some such programs are explicitly developed to help elders "age in place". Others set out not to prolong independent living in public housing, but simply to enhance

it. The variety of programs is impressive and encouraging, as is the conviction of many PHAs that resident well-being and good management are inseparable.

Some programs are well-funded, professionally staffed efforts that link the PHA with service providers throughout the community. Others are low-budget efforts that run largely on enthusiasm or the extraordinary organizing talents of a few people. It is clear from these examples that there are many ways in which resources can be created or stretched, communication and service delivery organized. Many of the programs described here are very new, responses to the increasing frailty of elder residents "aging in place" or to cut-backs in social service programs in recent years.

The PHAs we have spoken with have all been enthusiastic about letting others know about their programs, and also to learn about programs in other cities. We, too, want to continue learning about elder residents in public housing and the programs that serve them. We welcome any information and will do our best to share it as widely as possible.

6.0 Summary of Findings and Policy Implications

The body of this report has provided extensive information about elder residents of public housing in the United States. Demographics, assessments and opinions of administrators and service providers, and program descriptions have been presented in an effort to learn and to report as much as possible about this part of our population. This chapter summarizes the most important findings and attempts to put them in perspective.

Because our sample includes only large urban public housing agencies (PHAs), our findings may not be directly applicable to all public housing in the United States. For example, these large PHAs tend to have a higher proportion of family housing relative to elderly housing than is typical among smaller PHAs. Nevertheless, the 100 PHAs in our sample operate roughly 45 percent of all public housing units in the United States, and serve at least 30 percent of all elderly public housing residents. Our findings are thus directly applicable to a very large number of elders living in public housing in the U.S., and can provide helpful information about others through careful generalization.

This chapter discusses the meaning of the research and conclusions that have been presented throughout this report. The first part of the chapter summarizes major findings. The second part discusses their policy implications.

6.1 Major Findings

A. Demographic Characteristics of Elders in Public Housing

- Elders in public housing are more likely than other elders to live alone.

About three-quarters of all elderly households in urban public housing contain only one person. The average household size is 1.3, compared to 1.76 in the elderly population in general (Statistical Abstract of the United States, 1986, Table 58).

- Fifteen percent of the elderly households had at least one disabled member.

- About seventy percent of the elder-headed households had incomes between $3,000 and $6,000 per year. Only about one-quarter had incomes over $6,000. Only about five percent had incomes over $10,000 per year.

- The elder-headed households in urban public housing were heavily dependent on Social Security, and to a lesser extent on SSI. Very few--10 to 15 percent--had either wage income or private pension income, according to managers' reports.

- These heads of households are predominantly white, with approximately 60 percent falling into this ethnic group across most PHAs. New York City is a notable exception, with almost twice as many black households as white. Including New York, whites make up 46 percent of the total population, blacks 43 percent, Hispanics nine percent, and all other ethnic groups only about one percent.

B. Exit Data

- About 15 percent of the elder residents in these PHAs left public housing during the past year. Of these, about 40 percent died; about one-quarter moved to nursing homes or other care facilities; another quarter moved in with family or moved to other independent housing.

C. PHAs' Willingness to Accept or Retain Elders with Service Needs

- Most PHAs will not accept new applicants who must rely on PHA staff to arrange for services. Many more PHAs are willing to retain current elderly residents with the same level of need. However, there are many PHAs which require all elders to be capable of completely independent living.

Only about 10 percent of the PHAs will admit elderly applicants who will have to rely on PHA staff to provide or arrange for

services. About 60 percent admit applicants with service needs if they are able to make arrangements without PHA assistance. Fully 30 percent say they will not admit applicants who are not completely cabable of independent functioning.

However, about 30 percent of the PHAs will retain current residents who need PHA help to arrange necessary services. Some 10 percent require complete independence on the part of current residents as well. The remainder will retain residents who need help if they or others can arrange for the needed services.

About half the elderly developments and some 20 percent of the family developments reported operating under formal policies about retention of residents. The others do not. Anecdotal information, however, shows that some PHAs without formal policies nevertheless have well-developed practices which come into play in this situation. In general, lacking stated procedures, the responsibility falls to site managers to gather information and decide what to do.

At about 20 percent of the developments, PHA staff are routinely involved in hospital discharge planning for hospitalized residents. About 20 percent have stated policies concerning holding units for hospitalized residents. At the remainder, involvement in discharge planning is apparently rare, or at least sporadic, and holding units is left largely to the manager's judgment.

D. Differences between Elderly and Family Developments

- Over one-half the elderly households served by urban PHAs live in family developments or mixed family/elderly developments rather than all-elderly/handicapped developments. Over one-third live in family units rather than in units built or modified for elderly use.

Our survey of 100 large PHAs counted a total of 204,080 elderly households in housing owned and managed by these PHAs. (This does not include units leased under the Section 8 Existing Housing Program or similar leasing programs.) Of these households, about 48 percent live in elderly developments in units especially built for elderly or handicapped residents; 15 percent live in units built for the elderly but located in mixed family/elderly developments; and 37 percent live in unmodified family units located in family developments.

There are roughly 1.1 million elderly people living in public housing in the United States--about four percent of the nation's population aged 65 and over. If estimates made in this report are extended to the full public housing population, roughly 693,000 of these elders live in units built for the elderly and the remaining 407,000 live in units and developments built for family occupancy.

- Elder residents living in family developments are less likely to have many safety and security devices that are routinely provided in elderly developments, and are also less likely to have access to some important types of services.

Most family units lack amenities and modifications such as emergency buzzers, wheelchair access, and handrails in units. Such amenities are present in most specially built elderly units. However, few PHAs modify family units in which an elderly person happens to live. Further, elders living in family developments--even those living in specially built units--are less likely than residents of elderly developments to have such services as a working intercom or door buzzer system, paid overnight staff on site, a system for checking that a resident is OK each day, or any

type of health or medical facility on site.

- Elderly residents in elderly developments are somewhat older, on the average, than elderly residents in family developments.

About 42 percent of the elders living in elderly/handicapped developments were over 75 years of age, and about 14 percent were over 85. In family developments, about 31 percent were over 75 and six percent were over 85. This probably reflects two realities of public housing administration. (1) Because higher proportions of residents moved in about the same time and have aged in place together, average age has increased in elderly developments in a more patterned way than in family developments. (2) Because family developments tend to be less barrier-free and less service-enriched than elderly developments, residents are probably forced to move out more often when they become less able to live independently in this environment.

- About 11 percent of elderly households in elderly developments have lived in the development for 15 years or longer. The comparable figure for elderly households in family developments is 43 percent.

Residents of elderly developments cannot move in until they (or their spouse) are 62 or older. By contrast, elders rarely move into family units unless they have specially built elderly units. The elders who live in family developments therefore tend to be those who moved there earlier with their families, and who continue to live there after their children have grown up and moved out.

E. Other Characteristics of Elderly Developments and Units

- About 70 percent of elderly developments were built between 10 and 25 years ago. However, almost half the households living in these developments have been in residence less than five years.

This finding shows that there is quite a bit of turnover in elderly developments, and thus counterbalances the earlier finding about aging in place. In fact, both phenomena appear to be true. Because most elderly developments were built and first rented up between 1960 and 1975, many of them still have a "cohort" of original residents who have aged together. However, as these original residents have left, they have been replaced by others. If it is true that younger, healthier elders are most likely to apply for these units and to be accepted by the housing authority, this means that incoming residents will probably be younger, on average, than departing ones.

Thus, the phenomenon of many elder residents growing older simultaneously is a temporary artifact of the timing of federal subsidy programs, not a permanent fact of life in public housing. Nevertheless, PHAs cannot ignore the phenomenon. Current residents are almost certainly more frail than they were a decade ago. A decade from now, current residents may be comparatively less frail. But it is today's residents who must be served today. Interestingly, because of the needs of their present tenants, some PHAs are developing the capacity to accept frailer, more dependent residents in the future.

- Most elderly units are one-bedroom. About one-quarter, however, are zero-bedroom or efficiency.

Elder households in public housing are overwhelmingly one-

person. Unit sizes reflect this pattern: 69 percent of the units occupied by these households are one-bedroom, and only four percent are two-bedroom or larger. About 27 percent are zero-bedroom or efficiency. In addition to being less pleasant, more confining living quarters, eficiency units can be a problem when elder residents confront health crises that require temporary live-in help from a friend or relative. If there is no place for such a helper to live, the resident may be forced to move to a nursing home or other such institution because of the unit size, where otherwise he/she could remain in the unit with assistance.

- Most elderly developments are moderate in size. About half contain 50 to 150 units; 17 percent have fifty units or less; only 3 percent have more than 400 units.

Congregate facilities that were originally built or rehabilitated as congregates tended to be quite a bit smaller than general elderly developments. Congregates may be separate developments. However, they are frequently separate facilities contained within a larger elderly development. To the extent we were able to do so, we have only included free-standing congregates in the figures cited above.

- The term "congregate housing" is used to refer to a wide variety of situations in which some aspect of shared living is present.

"Congregate housing" is a term that is frequently used by PHAs to describe some elder housing. However, it is used so inconsistently throughout the country that no one meaning can be assumed without further inquiry. The most common use seems to be to designate developments that receive funding from HUD's Congregate

Housing Services Program (CHSP) demonstration to provide some services to a portion of the residents--e.g., 30 households in a building which houses 200. In general, this program does not pay for extensive redesign of living spaces, but for services which add an element of support to residents' lives. In most participating developments, this seems to be regular group meals--one meal a day in some places, one meal on certain days of the week in others. Some other services such as homemakers or personal care may also be funded by CHSP.

Some states have their own programs. In Massachusetts, for example, "congregate housing" refers to specially built developments which incorporate shared living in architectural design. Designs vary, but in general residents have private bedrooms and share other spaces--baths, kitchens, living rooms, and so forth. Cooperation between state housing and elder service agencies provides funding for services as well as construction. Prospective residents are carefully screened to determine their willingness to live in a congregate setting and their compatibility with current residents. Developments tend to be small and strive to maintain a balance between older and younger, and between robust and frail residents. New York state has a similar "Enriched Housing" program, combining funding for re-design with funding for services. New York requires residents to contribute a large proportion of their income in order to insure the provision of services which will allow the residents to remain until they need actual nursing care.

Some PHAs are also developing programs which combine services

with housing which they describe as "congregate facilities." We have heard it used, for example, to describe a development in which mutual responsibility was emphasized by management, and in which an active resident council and resident volunteer program were the primary resources. Others are organized to deliver extensive formal services, from meals and transportation to 5-day-per-week home care and specialized social services.

This report has included data on developments described as "congregate" by PHAs, but, because the concept lacks cohesion at present, these data do not come together to constitute particular findings. The movement toward more congregate facilities of any type, however, implies attention to elders' service needs, and is therefore an encouraging sign.

F. Information Collected by PHAs about Elderly Applicants and Residents

- About half of the PHAs surveyed do not regularly collect any information about elderly residents' functional level, medical histories, or service use or needs (beyond what is collected at the time of application).

- Both development managers and community service providers agree that the lack of an adequate needs assessment is a major barrier to identifying and meeting residents' service needs.

Fewer than 10 percent of responses by managers to questions about services and needs were based on needs assessments or other data. About half the managers said that reliable information about these matters was not available. In the absence of regular information about residents' status and needs, managers must rely on a variety of irregular sources--home visits during annual recertification of eligibility, contacts between residents and PHA staff,

complaints from other residents, and the like.

G. PHA Service Provision

- PHAs provide some services directly or through contracts with provider agencies in about half of all elderly developments and about 30 percent of family developments.

- About 20 percent of the PHAs say that no services or referral are available except on an emergency basis in elderly developments. About 28 percent say the same for family developments.

- In most PHAs (81 percent), managers are expected to play some service role, especially in emergencies. In about half, managers are routinely involved in services.

- Only about 40 percent of the developments appear to have on-site tenant services staff provided by the PHA; some 60 percent appear to have access to service staff who work out of the central administrative office.

- About one-half to two-thirds of managers have received some training in dealing with elders and their needs.

- Service providers seem to overestimate the extent to which PHAs provide services to their elder residents, the availability of on-site service staff, and the extent to which PHA staff are trained to help elders.

Throughout the survey, community service providers were much more likely than PHA managers or administrators to report that the PHA was meeting some need of its elder residents. This perception can lead providers to underestimate the need for outreach in public housing developments as well as the importance of taking the initiative in developing programs for residents.

Needs for Assistance

- Respondents estimate that 15 to 25 percent of elders in public housing suffer from social isolation, that similar percentages suffer from mobility impairment, depression, and memory impairment, and that some 10 percent suffer from alcoholism.

- Respondents estimate that one-fourth to one-third of these elders need help with transportation, shopping, caring for their units, and/or social and recreational activities. About 15 percent need help with meal preparation, getting out of their apartment, or with health care or medications.

Services Provided and Unmet Needs

- A high proportion of developments have some services available, used by some residents: meals-on-wheels, homemaker services, visiting nurses, transportation, social/recreational programs, case management or counseling, and so forth. Anecdotal information leaves the impression that such services may often reach only a few residents, however, leaving a large share of need unmet.

- About one-fourth to one-third of these elder residents appear to receive social/recreational and transportation services currently. Fifteen to 25 percent receive congregate meals, homemaker services, visiting nurses, health screening or clinic of some sort, friendly visitors programs, and counseling or case management.

The percentage of residents receiving some services is as high as respondents' estimates of the percentages that need them. However, as noted below, this does not preclude the existence of a sizeable unmet need for the same service. A transportation service, for example, may be <u>available</u> to all residents of a building, those who need it as well as those who do not, thus raising the percentage of those who are reported to have access to such a service. In a building which lacks a transportation system, however, those who need the service will be reported cortrectly as an "unmet need".

- Transportation, homemaker services, alcoholism treatment, friendly visitors, and social/recreational programs were most often listed by respondents as major unmet needs. In addition, meals-on-wheels, congregate meals, visiting nurses, health screening, and counseling or case management were cited as unmet needs by at least half of all respondents--managers and service providers.

- Major barriers to adequate service delivery included lack of good need assessment data, services unavailable in the community, lack of transportation to reach services, and need for more coordination and outreach.

- Several characteristics of the elders themselves were also cited as barriers--fear of dependency, emotional or physical impairments, and income too low to pay for services delivered for a fee.

This finding emphasizes the need for outreach to elders who cannot take the initiative to seek out services and for transportation for those who cannot reach a delivery site without assistance.

H. Variety of Approaches to Service Provision

It is evident from survey responses and program descriptions that PHAs throughout the nation are facing unprecedented demands for elder services, and that a variety of programs are developing in response to this demand. The primary factors behind the demand appear to be declines in social service and medical funding at the federal level, increasing average ages and increasing frailty among elders in public housing, and vacancies in elderly housing in some cities. These factors will be discussed at greater length in the section of this chapter which deals with policy implications.

Most PHAs appear to deal with elders' service needs on an *ad hoc* basis. Problems come to the attention of other tenants, maintenance or clerical staff, or the building manager, if any. In some PHAs--about 60 percent of those surveyed--the manager has

access to tenant services staff to help solve these problems. In the others, the manager must usually try to solve the problem without such help. (This is also generally true in small PHAs in our experience, but our data are only from large authorities.)

Chapter 5 reported on programs or program components in 23 authorities which go beyond an ad hoc approach. Others were reported to us, but these best exemplify the range that came to our attention. About eight percent of the PHAs surveyed had large-scale, comprehensive programs linking assessment, staff involvement in service access or delivery, a wide array of services, and well-defined rules for making occupancy decisions in a systematic manner. About the same number had programs that appeared to meet the same description except that they were smaller in scale or more informally defined. Thus, fewer than 20 percent of the PHAs had developed systematic approaches combining provision of a variety of services with clear procedures for deciding about eligibility for occupancy and for services. Several others had developed service components, some of them quite ambitious, which address particular problems faced by elder residents.

As these examples illustrate, PHA responses to aging in place cover a wide range of possibilities, all rational and defensible approaches to a difficult set of circumstances. Some PHAs choose the role of housing provider to healthy, independent elders. These PHAs will set high standards for elderly applicants, accepting only those who can live independently. They will also be vigilant about current residents who are developing problems involving increasing dependency. When such problems reach a defined level, the PHA's

response will be to initiate a process which leads to the resident's moving to alternative housing.

Some PHAs take a very different approach, and have developed sets of procedures aimed at keeping elders in units even after problems develop. A few go so far as to recruit and accept applicants with major problems requiring services. Some of these PHAs have developed facilities in which varying levels of care can be offered. This permits them to place a new tenant in an appropriate setting and lets them offer flexible levels of care to current tenants who are undergoing a crisis or who are becoming increasingly frail. Such PHAs tend to employ significant numbers of trained services staff and service planners, and also tend to be involved in coordinated programs with local elderly service providers. Several PHAs have taken the initiative in developing comprehensive approaches to the needs of their elder residents. However, the more specialized services tend to come from various community resources.

Most PHAs fall between these two extremes, and probably nearer the first than the second. However, many do not have consistent procedures which specify either approach. In fact, many appear not to have consistent sets of informal practices, either. In these PHAs, what happens will be driven more by circumstances than by PHA policy or direction. If a need arises, either individual or aggregate, the PHA or the manager of a particular development may attempt to deal with it in some way--perhaps by starting a special program. If an opportunity arises--for funding or for cooperation with a provider agency--the PHA or the manager may well take advantage of it. We did not make a systematic study of why or how

special projects were begun, but many look like responses of this sort to immediate needs or opportunities.

I. Importance of Creativity and Enthusiasm

We were struck by how often PHA respondents credited the creation and ongoing viability of a program to the enthusiasm and hard work of an individual or a small group of people. In a situation in which regular funding is rarely available in adequate amounts, many programs have come into existence by cooperation with other agencies, obtaining volunteer services, using the residents themselves in creative ways, and doing planning and fundraising through informal alliances. Creativity and enthusiasm cannot be brought into being as easily as voting in a new board policy, but they can be taken into consideration as key criteria when staffing decisions arise.

DRAFT

6.2 Policy Implications

The findings presented in this report have many implications--for federal and state policy, for local housing authority administration, and for agencies which provide services to elders. Persons who design, administer, and regulate policy at those levels are best equipped to recognize implications in their own area of expertise. We hope that they will use our findings to examine their own work and the assumptions it rests upon, and to initiate conversations with other interested parties--Congress and state legislatures, HUD, HHS, state housing and elderly affairs agencies, and the variety of local housing and service agencies which work with elders.

The most important potential outcome of this study is, in fact, just such a multifaceted conversation about housing and housing-related services for elders--and the actions that would result from that conversation. This discussion is our attempt, not to preempt that conversation, but to help it begin.

A. Federal and State Policy

As long as PHAs must find service money either in their operating budgets or through short-term fundraising efforts, services to elders will continue to be an afterthought in many PHAs.

This does not necessarily mean that services should be provided directly by the PHA. That decision depends on many factors only visible at the local level. In most cases, we think, arranging for services through provider agencies will be the preferred delivery method--if such agencies exist, if they offer the needed services, and if they are able to work cooperatively with each other and with the PHA.

The PHA itself, however, should be able to take the initiative in assessing needs and planning services for its residents as a group. This implies funding, perhaps in proportion to numbers of elder households, for PHAs to gather ongoing information about elder residents--characteristics, functional status, services received, and additional services needed, at a minimum--and to take the lead in bringing agencies together to develop coordinated programs. PHAs should be free to decide how best to do this in their own situation, e.g., through staff positions, consultants, subcontracting with local agencies, and so forth.

Service providers and their standard procedures usually treat clients as individual cases, not as members of a definable group. PHAs, by contrast, must consider residents in groupings--by floor, by building, by development, or citywide. When providers are able to acquire the PHA's perspective, innovative apporaches often result. Homemaker services can be

DRAFT

offered to a building, for example, rather than to isolated individuals. A coordinator can then assign services in a way that takes advantage of economies of scale. Rather than one hour to X, one hour to Y, one hour to Z, the coordinator might assign ten minutes to X (who needs help taking medications), 90 minutes to Y (who needs help with meal preparation and bathing), and one hour to a shopping trip for X, Y and Z. Or one part of a building can be set aside for frail elders who need assistance of various types, and the services arranged through cooperative planning with the appropriate agencies.

At present, neither HUD nor HHS provides funding of this type. Each agency tends to assert that the other--not themselves--should do so. This impasse leads to wasteful use of tax money in at least two ways. First, it does not take advantage of the economies of scale described above. Secondly, it leads to premature institutionalization of elders at higher levels of care than they actually need. If the only choice is independent public housing or a nursing home, many elders will be forced to move to nursing homes when they become partially or temporarily dependent. If varying levels of care are available within public housing, however, elders will have presumably less expensive alternatives available to them. (We did not study the costs of service delivery, so this conclusion is based on theory, not on our findings.)

The same situation tends to prevail at the state level. We believe that it should be corrected at both levels, preferably through legislative clarification and appropriations.

How the services themselves should be paid for is a complex issue, and one which goes beyond the scope of this study. Certainly the recipients' ability to pay should be taken into account, as should the funding available to provider agencies. Direct service provision by housing authorities may be the best option in some cases. It should be possible in such cases through some normal funding channel with defined decision criteria--e.g., the same source that provides the regular planning and coordination money recommended above.

The ability to use space flexibly and to make space available for services can greatly expand PHA options in service provision. Closely related to funding is the issue of restrictions on use of space. As our case studies demonstrate, housing authorities are often able to create useful programs at low cost to the PHA by making space available for the use of medical facilities, provider agency case managers, tenant organizations' activities, and other service providers. However, HUD's current regulations regarding "vacant" space penalize PHAs which do this. The regulations should be changed to encourage such use. State regulations should follow suit as appropriate.

We recommend that state and federal administrators consider

DRAFT

incentives for housing authorities to consider providing various levels of care to their elder residents. The needs of elder residents will change temporarily as they undergo life changes. They will also change irreversibly from time to time, leaving the resident needing more supportive services if he/she is to continue living independently. Most of the PHAs in our study are attempting to respond to these needs in some way. Only 10 percent of the PHAs, for example, say that they require current residents to move out when they cannot live alone without supportive services. The remaining 90 percent attempt in various ways and in varying degrees to permit residents to stay in place. PHAs that can monitor residents' condition regularly and that have standard procedures for bringing services into play will be best equipped to do this efficiently.

Facilities might be provided to which frailer elders can be moved, or variable services might be offered to residents in their current units or buildings. Bringing the services to the resident is preferable under most circumstances because it least disrupts the resident's life. However, it will not always be preferable and, in any case, may not be possible.

Housing authorities can be encouraged to consider the place that specially built or remodeled congregate, intermediate care , or even skilled nursing facilities can play in their overall strategy. HUD, HHS, and their state-level counterparts can provide special funding (perhaps on an interagency basis) for such projects. Joint projects with local service providers including hospitals and nursing homes can be encouraged.

Zero-bedroom "efficiency" apartments are not suitable units for elder residents who need supportive services, and are probably a false economy. Housing authorities should not be required or encouraged to build them, but rather should be encouraged to remodel existing efficiencies into 1-bedroom units. A certain degree of flexibility in use of space, even within a small one-person unit, can add greatly to a resident's ability to receive services that permit more "aging in place". If there is a temporary place for a family member to sleep, for example, families may be able to help residents through temporary physical and/or emotional crises without forcing the resident to move to a facility with more intensive services.

Coordinated planning for housing and services should be practiced at the federal and state levels and specifically encouraged at the local level. The service programs described in this report involve considerable cooperation between housing authorities and service provider agencies. This cooperation would be facilitated if it were part of a systematic approach that begins with federal- and state-level funding sources. When a major elderly building, rehabilitation, or modernization grant is made by HUD, service plans should be made for the new facility

DRAFT

and funding for an appropriate level of services "locked in"--perhaps by an interagency agreement with HHS. Similarly, major service initiatives should include explicit plans for how elders in public housing will be served. The potential economies of scale should be taken into account, not ignored. Massachusetts's coordinated planning of new congregate facilities provides a good model.

B. Implications for Local Administration and Program design

Both housing authorities and service providers can profit from a systematic approach to decisions about services. In its simplest form, a service program consists of three steps: (1) assess need, (2) decide whether services are feasible and approriate and, if so, which services and (3) provide the services. Every PHA and every provider agency must work through these steps, formally or informally. PHAs must consider both individual cases and aggregate needs of groups of residents.

There are, of course, many ways in which each step can be carried out, and many possible complicating factors. Aggregate need assessments, for example, are sometimes done by analyzing census data, sometimes by examining current service use, sometimes by asking tenants' organizations to make recommendations, sometimes by surveying residents, and so forth.

The three steps can become part of an ongoing system when procedures are defined and when step 3 leads back to step one again. That is, services currently provided are evaluated as part of deciding about current needs. When the process is thought of in this way, clearer decisions can be made about how to make it work smoothly. What information should be gathered? How and by whom should it be gathered? How should it be stored? How is it used in making decisions, e.g., about whether a current resident can continue to live independently or about whether a shared meal program will be worthwhile? How can utilization of particular services be measured and assessed? How can staff roles and procedures be defined to insure that practice follows policy?

Both PHAs and service provider agencies can often profit from doing some things jointly or cooperatively. As the above discussion makes clear, PHAs and providers must often carry out the same actions or make very similar decisions. Our case studies contain some striking examples of agencies' cooperating to make procedures more professional and decisions more uniform. The PISCES system for making assessments and sharing ongoing information about services received by individual elders is an example on a large scale. In a smaller way, agreements to provide space where nursing students can give health screening services and help with medications to elders as part of their fieldwork illustrate the same principle.

APPENDIX A

CENTRAL-LEVEL QUESTIONNAIRE

COVER SHEET: SURVEY OF LARGE PUBLIC HOUSING AUTHORITIES ABOUT ELDERLY RESIDENTS

PHA ID No.: / / / / / /
(LEAVE BLANK. FOR INTERNAL USE.)

HUD Region: _____

_____
Name of Housing Authority

_____
Mailing Address

_____
City State Zip Code

Main Telephone
Number _____
(Area Code) Number

PLEASE CORRECT ANY INCORRECT INFORMATION ABOVE.

Person(s) Responsible for Completing Questionnaire:

_____ _____
Name Name

_____ _____
Title Title

_____ _____
Address, if different from above Address, if different from above

_____ _____
Telephone Number, Extension Telephone Number, Extension

_____ _____
Questions Completed (identify by #) Questions Completed (identify by #)

INTRODUCTION

The phenomenon of "aging in place" is creating many unanticipated management problems for housing authorities. Already beset by aging stock, inadequate maintenance and modernization funds, and all the social problems that impact public housing, directors and managers also find that the aging of their elderly tenants creates new demands and pressures. Should efforts be made to keep elder tenants in their units as they become less capable of independent living? How do we decide when a tenant should no longer be housed? These and many other more detailed questions are being asked by managers of elderly housing of all types. They are especially important in public housing because of the concentrations of low-income elders and needs both in elderly developments and in some family developments.

At the same time, no one knows much about the numbers, needs, or situation of elder residents in the nation's public housing. Basic demographic data and knowledge of housing authority policies, problems, and procedures can help all local housing authority directors and managers. This is why we are conducting this survey -- with Robert Wood Johnson Foundation support -- to get your point-of-view and to get information that will be useful to you, your board, and your staff; and to support our own efforts to strengthen public housing. We thank you warmly for your cooperation.

CONFIDENTIALITY

Nothing in this survey asks for information about individual tenants. Nor would any responses identify individual tenants indirectly. Most questions ask about elderly developments, tenants, and policies authority-wide; a few questions ask about particular developments.

In analyses and reports, most material will be aggregated to the national level. That is, the major interest is in learning about numbers and needs by elderly tenants nationally, not in describing or comparing situations in local housing authorities. Reports will identify the participating authorities. Reports may also identify participating authorities by name if some unusual or innovative project is being undertaken.

PARTICIPATION

This is the first part of a two-part survey. It asks questions that can best be answered at the central office of a housing authority. The second part will be at the development level -- at a sample of two to four developments in selected cities.

We hope you will also agree to participate in Part Two. If you agree, this is what will happen.

- First, we will ask you — the Executive Director or the person he/she refers us to — to give us two names for each of the two to four developments chosen in your PHA: (1) the manager of that development and (2) a provider of services to the elderly (whether employed by the housing authority or by some other agency) who will have well-informed opinions about the needs of elderly people in the area served by the development.

- Second, we will send surveys similar to this one to each of these two people. These surveys will ask less than this one does about numbers and demographics and more about service provision and use.

That is all that is involved. Your participation in Part Two can help you as well as other housing authority administrators. It will give your managers and people in your community a chance to identify issues and propose approaches. It will mean that the information, recommendations, technical assistance, and other help coming back to you from us will be based on your needs and your situation.

Please indicate below whether you are willing for your PHA to be involved in the second part of this study. (CIRCLE ONE).

Yes	No
1	2

Signature of Executive Director _____ Date _____

SURVEY DESIGN

The survey is in four parts:

- Elderly Developments and Units
- Other Information about Elderly Units
- Demographic, Household, and Income Characteristics of Elder Tenants
- Policies on Admission, Service Provision, and Relocation of Elder Tenants

We ask you to decide which member of your staff can best answer each part, distribute the survey to them, then collect them and return it to us after it has been completed.

Most questions will be answered easily using numbers or facts that are routinely available. Others will ask for data that many housing authorities do not have on hand. We do not ask you to generate new numbers for this survey. Please give us "hard numbers" if you have them, but if not, please give us your best estimate. Many questions contain boxes you can check to tell us whether your response is based on counts or estimates, or when no information is available. Please use these boxes — we are very interested in knowing when there are simply no data to obtain. Some questions have been organized so you can report either numbers (if you have them) or estimated percentages (if no numbers are on hand). This makes the questions look more complicated, but should make them easier to answer; there is no need to give both numbers and percentages.

PLEASE READ THIS PAGE BEFORE STARTING PART ONE

First, we want to ask for a list, brochure, and/or map of your elderly developments (that is, federally- or state-funded conventional elderly and handicapped public housing. Do not include congregate facilities). Most PHAs have lists on hand already. If you do not have such a document, send us the closest thing you have. We want it to include:

1. All elderly developments

2. Numbers of units in each development

3. Age of developments (since first occupancy or last major rehabilitation)

4. Number of units occupied by elder-headed households (if development is mixed family and elderly)

5. Average age of elder heads of household (if information is available)

IF YOUR LIST, etc. HAS ITEMS 1, 2, AND 3, YOU MAY SKIP PART ONE OF THE QUESTIONNAIRE AND GO DIRECTLY TO PART TWO. IF NOT, PLEASE BEGIN WITH PART ONE.

PART ONE: ELDERLY DEVELOPMENTS & UNITS

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CONVENTIONAL ELDERLY DEVELOPMENTS. (By "conventional" we mean state or federally-assisted elderly public housing developments.) DO NOT INCLUDE CONGREGATE RESIDENCES IN THIS ANSWER. IF DATA ARE NOT AVAILABLE, PLEASE ESTIMATE OR CHECK THE "UNAVAILABLE" BOX.

1.a. Total number of elderly developments _____

1.b. Total number of elderly units _____

	1. How many of your elderly developments fall into each category ?	2. How many elderly units do you have in the developments in column 1?	3. Are your answers based on (a) exact counts, (b) estimates or (c) is info. unavail.? (CHECK ONE)
1.c. Development Size			
Under 50 units	_____	N/A	exact count a._____
51 to 150 units	_____	N/A	estimate b._____
151 to 400 units	_____	N/A	info. unavail. c._____
Over 400 units	_____	N/A	
1.d. Age of Development			
1 to 5 years	_____	_____	exact count a._____
6 to 10 years	_____	_____	estimate b._____
11 to 25 years	_____	_____	info. unavail. c._____
Over 25 years	_____	_____	
1.e. Bedroom Sizes			
0 (efficiency)	N/A	_____	exact count a._____
One Bedroom	N/A	_____	estimate b._____
Two or more Bedroom	N/A	_____	info. unavail. c._____

1.f. Overall Occupancy Rate in Conventional Elderly Developments _____ %

PART TWO: OTHER DEVELOPMENTS AND ELDERLY TENANTS

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ELDERLY CONGREGATE LIVING FACILITIES (By "congregate facilities" we mean state or federally-assisted elderly public housing developments designed for congregate living, e.g., with shared kitchen, dining or bathrooms.) IF DATA ARE NOT AVAILABLE, PLEASE ESTIMATE OR CHECK THE "UNAVAILABLE" BOX.

2.a. Total number of units in congregate facilities _____

	1. How many of your congregate developments fall into each category ?	2. How many elderly units do you have in the developments in column 1?	3. Are your answers based on (a) exact counts, (b) estimates or (c) is info unavail.? (CHECK ONE)
2.b. Size of Congregate Facility			
1-15 units	_____	N/A	exact count a. _____
16-30 units	_____	N/A	estimate b. _____
Over 30 units	_____	N/A	info. unavail. c. _____
2.c. Age of Congregate Facility			
0-5 years	_____	_____	exact count a. _____
Over 5 years	_____	_____	estimate b. _____
			info. unavail. c. _____
2.d. Bedroom Sizes			
0 (efficiency)	N/A	_____	exact count a. _____
one bedroom	N/A	_____	estimate b. _____
two or more bedrooms	N/A	_____	info. unavail. c. _____

2.e. Overall Occupancy Rate in Elderly Congregate Facilities ¶ ¶ ¶ % ¶ ¶ ¶

PLEASE ANSWER THE FOLLOWING QUESTION ABOUT YOUR CONVENTIONAL FAMILY DEVELOPMENTS. (By "conventional" we mean state or federally-assisted family public housing developments.) DO NOT INCLUDE CONGREGATE RESIDENCES IN THIS ANSWER. IF DATA ARE NOT AVAILABLE, PLEASE ESTIMATE OR CHECK THE "UNAVAILABLE" BOX.

3.a. Total number of units in family developments _____

3.b. Development Size

	1. How many of your family developments fall into each size category?	2. Are your answers based on (a) exact counts, (b) estimates, or (c) is the info. unavailable?
Under 50 units	_____	exact count a._____
51-150 units	_____	estimate b._____
151-400 units	_____	info. unavail. c._____
Over 400 units	_____	

3.c. Overall Occupancy Rate in Conventional Family Developments

¶ ¶
¶ % ¶
¶ ¶

3.d. How many units in your family developments are occupied by elder-headed households?

¶ ¶
¶ % ¶
¶ ¶

exact count a._____
estimate b._____
info. unavail. c._____

4. How many elderly persons live in your conventional and congregate elderly developments (regardless of whether they are heads of household)?

Number of elderly persons in elderly developments _____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

5. How many elderly people live in your family developments? (Include those who are not heads of household.)

Total number of elderly residents in family developments. _____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

6. Are there particular family developments with high concentrations (e.g., 25% or more) of elderly residents? If so, please list them below:

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

6.a. _____

Name of Family Development

_____

Address

Number of units in development? _____

Percent of units occupied by elder-headed households _____%

Age of development? _____

6.b. _____

Name of Family Development

_____

Address

Number of units in development? _____

Percent of units occupied by elder-headed households _____%

Age of development? _____

(ADD ADDITIONAL PAGES IF NECESSARY)

7.a. What percentage of units in your elderly developments (i.e., conventional and congregate) have each of the following amenities?

Amenity	Percentage
(1) Community space for recreational or educational uses?	_____
(2) Community space for provision of services	_____
(3) Handrails in units (e.g., bathrooms)	_____
(4) Call buttons in each apartment	_____
(5) Wheelchair modifications in units	_____

7.b. How often do you make modifications such as those listed in Question 7.a. in buildings or units occupied by elder tenants in family developments?

Always	1
Frequently	2
Seldom	3
Never	4

PART THREE: DEMOGRAPHIC, HOUSEHOLD, AND INCOME CHARACTERISTICS

8.a. How many elder heads of household do you have in each of the following age categories? (IF THE AGE CATEGORIES IN YOUR RECORDS CANNOT BE MADE TO MATCH THESE, PLEASE CHECK THAT BOX AND ANSWER QUESTION 8.b INSTEAD. IF YOU DO NOT HAVE SEPARATE DATA FOR ELDERLY OR FAMILY DEVELOPMENTS, PLEASE FILL IN AS MUCH AS YOU CAN — E.G., ONLY ELDERLY DEVELOPMENTS OR ONLY TOTALS.)

Age Category	Number of elder-headed households: In elderly Developments	In family Developments	Total
62 to 64	_____	_____	_____
65 to 74	_____	_____	_____
75 to 84			
85 & Over	_____	_____	_____

Our records do not match these categories. See Question 8b. [ ]

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

8.b. (ANSWER THIS QUESTION ONLY IF YOU DID NOT ANSWER QUESTION 8.a.) Please give the ages of your elder heads of household in the categories used in your record-keeping system. (IF YOU DO NOT HAVE SEPARATE DATA FOR ELDERLY AND FAMILY DEVELOPMENTS, PLEASE ANSWER AS MUCH AS YOU CAN — E.G., ONLY ELDERLY DEVELPMENTS OR ONLY TOTALS.)

Age Category	Number of Elder-headed Households: In elderly Developments	In family Developments	Total
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

9. How large are your elder-headed households?

Household Size	Number of elder-headed households
1 person	_____
2 persons	_____
3 or more people	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

10.a. What is the composition of your elder-headed households?

Household Type	Number of elder-headed households
Single person living alone	
Single parent with child(ren)	
Couple living together with no child(ren)	
Couple with child(ren)	
Related or unrelated adults (e.g., friends, siblings, etc.)	
Other:	

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

11. How many of your elder heads of household are disabled (by HUD's definition) or have a disabled member of their household? (IF YOU DO NOT HAVE A COUNT, PLEASE ESTIMATE THE NUMBER OR PERCENT WHO ARE DISABLED)

	Number	[OR]	Percent
Elder-headed households with disabled member:			

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

12.a. How many of your elder-headed households fall into each of the following net income categories? (USE YOUR INCOME ELIGIBILITY FIGURES.)

Income Category	Number of elder-headed households
$0 - 2,999	
$3,000 - 9,999	
$10,000 - 14,999	

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

12.b. What percentage of your elder-headed households have incomes between 50% and 80% of area median income? _____

What percentage of your elder-headed households have incomes below 50% of area median income? _____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

13. How many of your elder-headed households receive income from the following income sources?

Income Source	Number of Elder-headed Households
Wages	_____
AFDC	_____
General Relief	_____
Social Security	_____
SSI	_____
Other: _____	_____
_____	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

14. How many of your elder-headed households are of the following racial or ethnic backgrounds?

Background	Number of Elder-headed Households
White	_____
Black	_____
Hispanic	_____
American Indian	_____
Asian	_____
Other: _____	_____
_____	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

15. How many years have your elder heads of household lived in their current development?

	Number of elder-headed households		
Length of Tenure	In elderly Developments	In family Developments	Total
Less than 5 years	_____	_____	_____
6 to 15 years	_____	_____	_____
more than 15 years	_____	_____	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

PART FOUR: POLICIES ON ADMISSION, SERVICE PROVISION, AND RELOCATION

16. Please rank those items below which are taken into account in your selection criteria for elderly tenants (1 = HIGHEST PRIORITY; ITEMS CAN HAVE EQUAL RANK):

Category	Rank
Applicants involuntarily displaced by public or private action	____
Applicants with excessive rent burden	____
Applicants with incomes below 50% of your area's median income	____
Applicants with incomes between 50% and 80% of your area's median income	____
Residents of your service area	____
First-come-first-served (no preferences among eligible applicants)	____
Other (specify): _____	____
_____	____

17.a. Which statement below best describes your formal or informal policy about offering a unit to an elderly applicant who meets other screening criteria? (CHECK ONLY ONE):

(1) Applicants must be capable of complete independent functioning without any assistance. ____

(2) Applicants may be offered units if they need minimal services to assist in maintaining themselves and their units, and can arrange for this assistance. ____

(3) Applicants may be offered units if they need minimal services to assist in maintaining themselves and their units even if they must rely on PHA staff to arrange for these services. ____

(4) Applicants may be offered units even if they need on-going assistance, as long as they can arrange for all supportive services. ____

(5) Applicants may be offered units if they need ongoing assistance, even if they must rely on PHA staff to arrange for these supportive services. ____

(6) Other (specify): _____
_____ ____

17.b. Do you have a formal policy to cover this situation?

	Yes	No
(IF YES, PLEASE ATTACH A COPY OF YOUR POLICY.)	1	1

18.a. Which statement below best describes your formal or informal policy about <u>permitting tenants to remain in units?</u> (CHECK ONE):

(1) Tenants must be capable of complete independent functioning without any assistance. _____

(2) Tenants may remain if they need minimal services to assist in maintaining themselves and their units, and can arrange for this assistance. _____

(3) Tenants may remain if they need minimal services to assist in maintaining themselves and their units even if they must rely on PHA staff to arrange for these services. _____

(4) Tenants may remain even if they need ongoing assistance as long as they can arrange for all supportive services. _____

(5) Tenants may remain if they need ongoing asistance, even if they must rely on PHA staff to arrange for these supportive services. _____

(6) Other (specify): _____ _____

18.b. Do you have a formal policy to cover this situation?

	Yes	No
(IF YES, PLEASE ATTACH A COPY OF YOUR POLICY.)	1	2

19.a. How many elderly households are on your waiting list for public housing units? _____

19.b. What is the average length of time an elder person is on the waiting list for:

a studio (0-bedroom) unit _____

a 1-bedroom unit _____

a 2- or more bedroom unit _____

19.c. What else effects time on the waiting list other than availability of a specific unit size?_____

_____

20. What percentage of your elderly units became vacant during the last year for which you have records?

percentage of elderly units _____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

21. Of the elderly tenants who vacated units during that year (see Question 20), what percentage...

moved in with family? _____

moved to other independent housing? _____

moved to nursing homes or other care facility? _____

died? _____

other? (specify)_____ _____

_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

22. Which statements best describe your policies or practices on provision of services to elders, e.g., homemaker services, Visiting Nurses, Meals-on-Wheels? (PLEASE DISTINGUISH BETWEEN ELDERLY AND FAMILY DEVELOPMENTS. CHECK ALL WHICH APPLY.)

	Elderly Developments	Family Developments
Services such as these are provided in most developments directly by PHA staff or through PHA contracts with service providers in the community.	_____	_____
Services such as these are not provided in most developments, but the PHA has service staff who are available to all elder residents to help obtain services from community agencies.	_____	_____
Services and/or assistance to obtain them are routinely provided in some developments and not in others (e.g., depends on managers' initiative, availability of special funding, etc.)	_____	_____
Services and/or assistance in obtaining them are provided only in emergency situations in all or most developments.	_____	_____
Services and/or assistance in obtaining them are not provided in most developments.	_____	_____
Other (specify): _____ _____	_____	_____

23. Assisting elders to obtain services is within the stated responsibilities of: (CIRCLE ONE FOR EACH PERSONNEL CATEGORY.)

	Yes	No
Development managers	1	2
Tenant services staff at the central level	1	2
Tenant services staff at the development level	1	2
Custodial, clerical or other administrative support staff at the development level	1	2
Other (specify): _____ _____	1	

24. Assistance to elders in obtaining services is actually provided by: (CHECK ALL WHICH APPLY.)

	Routinely	Primarily in emergencies	Differs among developments
Development managers	____	____	____
Tenant services staff at the central level	____	____	____
Tenant services staff at the development level	____	____	____
Custodial, clerical or other administrative support staff at the development level	____	____	____
Other: (Specify): _____	____	____	____
_____	____	____	____

25. Does your housing authority collect information routinely about elder residents concerning the following, either authority-wide or in some developments? (CHECK THE COLUMN WHICH APPLIES FOR EACH ITEM.)

	Yes, Authority-wide	Yes, Some developments	Not collected
Changes in level of independent functioning (e.g., ability to prepare meals or maintain unit)	____	____	____
Services requested or received	____	____	____
Medical history (e.g., physical impairments, medications and hospitalizations or other emergencies)	____	____	____

If Yes, is the information in a form that could be made available to us?

Yes	No
1	2

26. Do the following housing authority staff receive any formal training about the needs of elder residents and services available to them?

	Yes	No
Development managers	1	2
Tenant services staff (development level)	1	2
Tenant services staff (central level)	1	2
Other (e.g., clerical, maintenance, security staff): _____	1	2

If yes, please briefly describe this training: _____

_____

_____

27. Which of the following are significant management problems with regard to the elderly in your developments? (PLEASE CHECK AND RANK IF POSSIBLE — 1 = GREATEST PROBLEM(S); ITEMS CAN HAVE EQUAL RANK.)

	Elderly Developments	Family Developments
Vandalism	_____	_____
Crime against elderly	_____	_____
Disputes among elder residents/ between elder and younger residents	_____	_____
Disputes between elder residents and management	_____	_____
Elder residents' inability to maintain units	_____	_____
Alcoholism	_____	_____
Vacancies	_____	_____
Requests for services beyond capacity of PHA to provide	_____	_____
Obtaining alternative placement for tenants no longer able to live in development	_____	_____
Obtaining cooperation of family when needed	_____	_____
PHA staff "burnout"	_____	_____
Inability to provide/arrange needed services	_____	_____
Other: _____	_____	_____
_____	_____	_____
None of the above	_____	_____

28. When an elder resident is hospitalized or moved to a health care facility for a short-term stay, does your board have a policy governing whether a representative of your housing authority is involved in discharge planning when they are released?

Yes	No
1	2

If yes, please identify person/describe procedure: _____

_____

_____

(OR ATTACH A COPY OF POLICY STATEMENT IF POSSIBLE.)

29. Does your housing authority have a policy which specifies how long a rental unit is held when an elder resident is hospitalized or moved to a nursing home temporarily?

Yes	No
1	2

If yes, please describe: _____

_____

_____

(OR ATTACH A POLICY STATEMENT IF POSSIBLE.)

30. Do you have authority-wide procedures for making the determination that a tenant can no longer live independently?

Yes	No
1	2

If yes, please describe the procedures briefly: _____

_____

_____

_____

(OR ATTACH A POLICY STATEMENT IF POSSIBLE.)

31. Is your housing authority currently involved in any special projects or programs related to elder residents' needs for services?

Yes	No
1	2

If yes, please describe: _____

_____

_____

(OR ATTACH DESCRIPTIVE INFORMATION IF POSSIBLE.)

32. Has your housing authority recently developed any new policies to deal with problems created by elder residents "aging in place"?

Yes	No
1	2

If yes, please describe: _____

_____

_____

(OR ATTACH A POLICY STATEMENT IF POSSIBLE.)

33. Are there any other important aspects of your housing authority's policies and practices regarding elder residents which have not been covered in this questionaire, but which you think we should know about?

Yes	No
1	2

If yes, please describe: _____

_____

_____

(PLEASE ATTACH DESCRIPTIVE INFORMATION IF POSSIBLE.)

34. Have you done any special studies or reports on your elderly tenants?

Yes	No
1	2

(IF YES, PLEASE ATTACH A COPY IF POSSIBLE.)

APPENDIX B

DEVELOPMENT-LEVEL QUESTIONNAIRE

COVER SHEET: SURVEY OF PUBLIC HOUSING DEVELOPMENTS ABOUT ELDERLY RESIDENTS

SURVEY ID No.: / / / / / / 01-05

DEVELOPMENT ID No.: / / /

(LEAVE BLANK. FOR INTERNAL USE.)

Name of Housing Authority

Name of Development

Mailing Address of Development

City State Zip Code

Main Telephone Number (Area Code) Number

Person Responsible for Completing Questionnaire:

Name

Title

Address, if different from above

Telephone Number, Extension

INTRODUCTION

The phenomenon of "aging in place" is creating many unanticipated management problems for housing authorities. Already beset by aging stock, inadequate maintenance and modernization funds, and all the social problems that impact public housing, directors and managers also find that the aging of their elderly tenants creates new demands and pressures. Should efforts be made to keep elder tenants in their units as they become less capable of independent living? How do we decide when a tenant should no longer be housed? These and many other more detailed questions are being asked by managers of elderly housing of all types. They are especially important in public housing because of the concentrations of low-income elders both in elderly developments and in some family developments.

At the same time, no one knows much about the numbers, needs, or situation of elder residents in the nation's public housing. Basic demographic data and knowledge of housing authority policies, problems and procedures can help all local housing authority directors and managers. This is why we are conducting this survey -- with Robert Wood Johnson Foundation support -- to get your point-of-view and to get information that will be useful to you and other housing authority staff. We thank you warmly for your cooperation.

CONFIDENTIALITY

Nothing in this survey asks for information about individual tenants. Nor would any responses identify individual tenants indirectly. Most questions ask about the development, its tenants as a group, and policies.

In analyses and reports the information will be aggregated. That is, the major interest is in learning about the numbers and needs of elderly tenants nationally, not in describing or comparing situations in local housing authorities. However, reports will identify the participating authorities and developments. Reports may also site particular authorities and developments if some innovative project for serving the elderly is being undertaken.

INSTRUCTIONS

The survey is in four parts:

- o Development Characteristics (Question 1)
- o Elderly Households and Individuals (Question 2-10)
- o Admission and Retention (Question 11a-18)
- o Services and Service Needs (Question 19-28)

The first three parts are to be filled out by the manager of the development named on the cover sheet of this questionnaire. The fourth part is to be filled out both by the manager and by the "person who knows about services." We have sent a copy to each of these two people. Please fill them out separately and independently. We aren't trying to catch you disagreeing with each other, but we do want to get both perspectives.

Most questions can be answered easily using numbers or facts that are routinely available. Others may ask for data that you do not have on hand. We do not ask you to generate new numbers for this survey. Please give us "hard numbers" if you have them, but if not, please give us your best estimate. Many questions contain boxes you can check to tell us whether your response is based on counts or estimates, or when no information is available. Please use these boxes -- we are very interested in knowing when there are simply no data to obtain. Some questions have been organized so you can report either numbers (if you have them) or estimated percentages (if no numbers are on hand). This makes the questions look more complicated, but should make them easier to answer; there is no need to give both numbers and percentages.

PART ONE: DEVELOPMENT CHARACTERISTICS

(THIS PART IS TO BE COMPLETED BY THE DEVELOPMENT MANAGER FOR THE DEVELOPMENT NAMED ON THE COVER SHEET)

1. What type of development is it?

_____ Elderly/Handicapped only
_____ Family
_____ Mixed Family/Elderly (i.e. some units are specifically designated as elderly units)

1b. How many units of each size are in the development?

	Designated Elderly Units	Family Units (not designated as elderly, though may be occupied by elderly)
0-bedroom	_____	_____
1-bedroom	_____	_____
2-bedrooms	_____	_____
3 or more bedrooms	_____	_____
total units	_____	_____

1c. What number and types of buildings do you have in the development

	#
High-rise or elevator buildings	_____
Walk-up multi-unit buildings	_____
Townhouses or garden apartments	_____
Mixed high-rise/low-rise buildings	_____
Other (specify)_____	_____

1d. The development is

_____ on a single contiguous site
_____ on scattered sites

1e. The development was completed in the year _____.

1f. The building was modernized

_____	partly (some buildings)	year	_____
_____	fully (all buildings)	year	_____
_____	not modernized		

(IF MODERNIZED:)

What building elements were modernized/added
(e.g. windows, heating systems, wheelchair modifications)?

_____

_____

_____

1g. Do you manage only this development or are you also responsible for other developments?

_____ only this development
_____ others too -- number of others? _____

1h. Do you have an office at this development?

Yes _____
No _____

1i. (IF YES) How many days per week do you normally spend at this office? What hours of the day are you normally here?

Number of days per week _____

Normal hours per day: from _____ __M to _____ __M

PART TWO: ELDERLY HOUSEHOLDS AND INDIVIDUALS

(THIS PART IS TO BE COMPLETED BY THE DEVELOPMENT MANAGER, FOR THE DEVELOPMENT NAMED ON THE COVER SHEET.)

2a. How many elder-headed households live in the development?

_____ Number of elder-headed households

2b. How many elderly individuals live in the development?

_____ Number of elderly individuals

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

3a. How many elder heads of household do you have in each of the following age categories? (IF THE AGE CATEGORIES IN YOUR RECORDS CANNOT BE MADE TO MATCH THESE, PLEASE CHECK THAT BOX AND ANSWER QUESTION 3b. INSTEAD.)

Age Category	
62 to 64	_____
65 to 74	_____
75 to 84	_____
85 and Over	_____

Our records do not match these categories. See Question 3b. [ ]

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

3b. (ANSWER THIS QUESTION ONLY IF YOU DID NOT ANSWER QUESTION 3a.) Please give the ages of your elder heads of household in the categories used in your record-keeping system.

Age Category	Number of Elder-headed Households
_____	_____
_____	_____
_____	_____
_____	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

4. How large are your elder-headed households?

Household Size	Number of elder-headed households
1 person	_____
2 persons	_____
3 or more people	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

5. What is the composition of your elder-headed households?

Household Type	Number of elder-headed households
Single person living alone	_____
Single parent with child(ren)	_____
Couple living together with no child(ren)	_____
Couple with child(ren)	_____
Related or unrelated adults (e.g., friends, siblings, etc.)	_____
Other: _____	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

6. How many of your elder heads of household are disabled (by HUD's definition) or have a disabled member of their household? (IF YOU DO NOT HAVE A COUNT, PLEASE ESTIMATE THE NUMBER OR PERCENT WHO ARE DISABLED)

	Number	[OR]	Percent
Elder-headed households with disabled member:	_____		_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

7a. How many of your elder-headed households fall into each of the following net income categories? (USE YOUR INCOME ELIGIBILITY FIGURES.)

Income Category	Number of elder-headed households
$ 0 - 2,999	_____
$ 3,000 - 5,999	_____
$ 6,000 - 9,999	_____
$ 10,000 - 14,999	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

7b. What percentage of your elder-headed households have incomes between 50% and 80% of area median income? _____

What percentage of your elder-headed households have incomes below 50% of area mediam income? _____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

8. How many of your elder-headed households receive income from the following income sources?

Income Source	Number of elder-headed households
Wages	_____
AFDC	_____
General Relief	_____
Social Security	_____
SSI	_____
Public or Private Pensions	_____
Other: (Specify)	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

9. How many of your elder-headed households are of the following racial or ethnic backgrounds?

Background	Number of elder-headed households
White	_____
Black	_____
Hispanic	_____
American Indian	_____
Asian	_____
Other: _____	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

10. How many years have your elder heads of household lived in their current development?

Length of Tenure	Number of elder-headed households
Less than 5 years	_____
6 to 10 years	_____
11 to 15 years	_____
16 to 20 years	_____
more than 20 years	_____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

PART THREE: ADMISSION AND RETENTION

(THIS PART IS TO BE COMPLETED BY THE DEVELOPMENT MANAGER, FOR THE DEVELOPMENT NAMED ON THE COVER SHEET.)

11a. Which statement below best describes your formal or informal policy about offering a unit to an elderly applicant who meets other screening criteria? (CHECK ONLY ONE:)

(1) Applicants must be capable of complete independent functioning without any assistance. _____

(2) Applicants may be offered units if they need minimal services to assist in maintaining themselves and their units and can arrange for this assistance. _____

(3) Applicants may be offered units if they need minimal services to assist in maintaining themselves and their units even if they must rely on PHA staff to arrange for these services. _____

(4) Applicants may be offered units even if they need on-going assistance with personal care and housekeeping, as long as they can arrange for the necessary supportive services. _____

(5) Applicants may be offered units if they need ongoing assistance with personal care and housekeeping, even if they must rely on PHA staff to arrange for these supportive services. _____

(6) Other (specify): _____ _____

11b. Do you have a formal policy to cover this situation?

Yes _____
No _____

(IF YES, PLEASE ATTACH A COPY OF YOUR POLICY.)

12a. Which statement below best describes your formal or informal policy about permitting tenants to remain in units? (CHECK ONE):

(1) Tenants must be capable of complete independent functioning without any assistance. _____

(2) Tenants may remain if they need minimal services to assist in maintaining themselves and their units, and can arrange for this assistance. _____

(3) Tenants may remain if they need minimal services to assist in maintaining themselves and their units even if they must rely on PHA staff to arrange for these services. _____

(4) Tenants may remain if they need ongoing assistance as long as they can arrange for all supportive services. _____

(5) Tenants may remain if they need ongoing assistance, even if they must rely on PHA staff to arrange for these supportive services. _____

(6) Other (specify): _____

_____ _____

12b. Do you have a formal policy to cover this situation?

Yes _____
No _____

(IF YES, PLEASE ATTACH A COPY OF YOUR POLICY)

13a. Do you routinely collect information before an elderly tenant moves in concerning the following? (CIRCLE ONE RESPONSE FOR EACH ITEM.)

	Yes, collected from all elderly	Yes, collected from some elderly if it seems to be a potential problem	No, not collected
Level of independent functioning (e.g., ability to prepare meals or maintain unit)	1	2	3
Medical history (e.g., physical impairments, medications, hospitalizations)	1	2	3
Social network (e.g., availability of family or friends to provide assistance	1	2	3
Services currently received	1	2	3

13b. Do you routinely collect information on an ongoing basis from current residents concerning the following?

	Yes, collected from all elderly	Yes, collected from some elderly if it seems to be a current or potential problem	No, not collected
Level of independent functioning (e.g., ability to prepare meals or maintain unit)	1	2	3
Medical history (e.g., physical impairments, medications, hospitalizations)	1	2	3
Social network (e.g., availability of family or friends to provide assistance	1	2	3
Services currently received	1	2	3

13c. (IF YOU ANSWERED "YES" TO QUESTION 13a OR QUESTION 13b, PLEASE ANSWER 13c AND 13d. OTHERWISE SKIP TO QUESTION 14)

Is this information collected by PHA staff or by another service agency?

____ PHA staff
____ another agency (SPECIFY)_____

13d. Is the information in a form that could be made available to us?

Yes ____
No ____

14. When an elder resident is hospitalized or moved to a health care facility for a short-term stay, is a representative of the housing authority routinely involved in discharge planning when they are released?

Yes ____
No ____

If yes, please identify person/describe procedure:_____

_____

_____

(OR ATTACH A COPY OF POLICY STATEMENT IF POSSIBLE.)

15. Do you have a policy which specifies how long a rental unit is held when an elder resident is hospitalized or moved to a nursing home temporarily?

Yes ____
No ____

If yes, please describe: _____

_____

(OR ATTACHED POLICY STATEMENT IF POSSIBLE.)

16. Do you have standard procedures for making the determination that a tenant can no longer live independently?

Yes ____
No ____

If yes, please describe the procedures briefly:_____

_____

_____

(OR ATTACH A POLICY STATEMENT IF POSSIBLE.)

17. What percentage of your elderly units became vacant during the last year for which you have records?

percentage of elderly units _____

18. Of the elderly tenants who vacated units during that year (see Question 17), what percentage...

moved in with family? _____
moved to other independent housing? _____
moved to nursing homes or other care facility? _____
died? _____
other? (specify)_____ _____
_____ _____

Source of Data: [ ] Count [ ] Estimate [ ] Not Available

PART FOUR: SERVICES AND SERVICE NEEDS

(THIS PART IS TO BE COMPLETED BY THE DEVELOPMENT MANAGER AND A PERSON FAMILIAR WITH ELDER SERVICES AND SERVICE NEEDS IN THE DEVELOPMENT NAMED ON THE COVER SHEET. WE HAVE SENT EACH OF YOU A COPY. PLEASE COMPLETE YOURS SEPARATELY AND RETURN IT TO US.)

19a. Which of the following resources or facilities are present in the development itself?

	YES	NO
Lobby or other public "sitting room" space?	1	2
Community space for meetings or service provision?	1	2
Nursing station or other medical facility? (Specify: _____)	1	2
Working intercom/door buzzer system?	1	2
Working emergency buzzer or call system?	1	2
Door-cards or other system for daily check that residents are OK?	1	2
Paid, on-site overnight staff for residents to call on in emergencies?	1	2

19b. Which of the following services or resources are routinely delivered on-site? ("Routinely" means at least weekly or more frequently for meals, transportation, recreation, homemaker/home health aide/home nursing services, and counseling/service coordination services; at least four times per year for health clinic/health screening services.) (CIRCLE ONE RESPONSE FOR EACH ITEM.)

	Yes, operated by PHA	Yes, operated by another agency	No, but available off-site	No, not readily available
Case manager/service coordinator to diagnose needs and help organize/allocate services?	1	2	3	4
Congregate meals	1	2	3	4
Meals-on-Wheels	1	2	3	4
Social/recreation program	1	2	3	4
Transportation program	1	2	3	4
Health clinic (general medical care)	1	2	3	4
Health screening (e.g., vision, blood press.)	1	2	3	4
Homemaker/Home Health Aide assistance	1	2	3	4
Public Health/Visiting Nurse assistance	1	2	3	4
Social and personal counseling	1	2	3	4
Peer assistance (formal program)	1	2	3	4
Alcoholism treatment	1	2	3	4
Other (specify):				
_____	1	2	3	4

Comments: _____

_____

20a. As far as you know, assisting elders to obtain services is within the stated responsibilities of: (CIRCLE ONE FOR EACH PERSONNEL CATEGORY.)

	YES	NO
The development manager	1	2
Tenant services staff who work at the central level	1	2
Tenant services staff assigned to the development	1	2
Custodial, clerical or other administrative support staff at the development level	1	2
Other (specify): _____		
_____	1	2

20b. As far as you know, assistance to elders in obtaining services is actually provided by: (CHECK ALL WHICH APPLY.)

	Routinely	Primarily in emergencies
The development manager	1	2
Tenant services staff who work at the central level	1	2
Tenant servies staff assigned to the development	1	2
Custodial, clerical or other administrative support staff at the development level	1	2
Other: (Specify)_____	1	2
_____		

21. Based upon needs assessments or other sources of information, please estimate as accurately as possible the number or percent of elders who experience problems associated with the following (WHETHER OR NOT THE PROBLEM IS BEING ADDRESSED, EITHER BY FAMILY OR SERVICE PROVIDERS, IS A SEPARATE QUESTION--SEE QUESTION 22)

	Number	[OR]	Percent
Social isolation	____		____
Mobility impairment	____		____
Self-neglect	____		____
Malnutrition	____		____
Depression	____		____
Alcoholism	____		____
Erratic behavior	____		____
Memory impairment	____		____
Other emotional or cognitive impairment	____		____
Other (specify): _____	____		____

Source of information:

Needs assessment or routine data collection [ ]

Personal observation and contacts with PHA or service provider staff [ ]

Other: _____ [ ]

Accurate information about elders' problems is not readily available [ ]

22. Based upon needs assessment or other sources of information please estimate as accurately as possible the approximate number or percent of elders who need assistance beyond that provided by family members with each activity listed below. (WHETHER OR NOT THE ASSISTANCE IS CURRENTLY BEING PROVIDED IS A SEPARATE QUESTION -- (see Question 23.)

	Number	[OR]	Percent
Transportation	____		____
Shopping	____		____
Cleaning or caring for unit	____		____
Preparing meals	____		____
Getting out of the apartment	____		____
Getting around the apartment	____		____
Personal care (e.g., shaving, bathing, etc.)	____		____
Health monitoring/medications	____		____
Budgeting and paying bills	____		____
Social/recreational activities	____		____
Other (Specify):_____	-----		------

Source of information:

Needs assessment or routine data collection [ ]

Personal observation and contacts with PHA or service provider staff [ ]

Other:_____ [ ]

Accurate information about elders' needs is not readily available. [ ]

23. Please estimate as accurately as possible the number or percentage of elder residents who actually receive or utilize the following services.

	Number	[OR]	Percent
Meals-on-wheels	____		____
Congregate meals	____		____
Social/receational program	____		____
Transportation program	____		____
Homemaker/Home Health Aide	____		____
Public Health/Visiting Nurse	____		____
Health screening/clinic	____		____
Friendly Visitors	____		____
Counseling/Case management	____		____
Alcoholism treatment	____		____
Other (specify): _____	____		____

Source of information:

Needs assessment or routine data collection [ ]

Personal observation and contacts with LHA or service provider staff [ ]

Other: _____ [ ]

24. Please rank the services listed below according to the most serious unmet needs. (That is, services are not provided or the services provided do not adequately meet elder resident's needs -- 1 = most needed, and items can have equal rank.)

	Rank
Meals-on-Wheels	____
Congregate meals	____
Social/recreational program	____
Transportation program	____
Homemaker/Home Health Aide	____
Public Health/Visiting Nurse	____
Health screening/clinic	____
Friendly Visitors	____
Counseling/Case management	____
Alcoholism treatment	____
Other (Specify):_____	____
_____	____

Source of information:

Needs assessment or routine data collection [ ]

Personal observation and contacts with PHA or service provider staff [ ]

Other: _____ [ ]

25. What, in your opinion, are the primary obstacles to elders receiving needed services? Please check and rank if possible all those items below which apply -- 1 = greatest obstacle(s), and items can have equal rank.

	Rank
Insufficient services available in the community or on-site	____
Lack of systematic assessment of elder residents' needs	____
Insufficient coordination of services by providers or LHA staff	____
Inadequate outreach by providers	____
Insufficient information and referral services or assistance in requesting service	____
Inadequate transportation to the delivery site	____
Elders' economic obstacles:	
inadequate income	____
over-income	____
Elders' fear of dependency	____
Elders' physical or emotional impairments	____
Language/cultural barriers	____
Other (specify): _____	____
_____	____

26. As far as you know, have the following housing authority staff received any training about the needs of elder residents and services available to them?

	Yes	No
Development managers	1	2
Service coordinators (site level)	1	2
Tenant services staff (central level)	1	2
Other (e.g., clerical, maintenance, security staff): _____	1	2

If yes, please briefly describe this training: _____

_____

_____

27. Which of the following, in your opinion, are significant management-related problems in this development? Please check and rank if possible -- 1 = greatest problem(s), and items can have equal rank.

	Rank
Deterioration of physical plant	____
Vandalism	____
Crime against elderly	____
Rent arrearages by elderly	____
Disputes among elder residents/between elder and younger residents	____
Disputes between elder residents and management	____
Elder residents' inability to maintain units	____
Elder residents' inappropriate requests for assistace (e.g., from maintenance staff)	____
Need for more services to support elder residents' health and safety	____
PHA staff "burnout"	____
Other: _____	____
_____	____

28. Is there anything else we should know to understand the situation of elder residents, management staff, and service providers at the development named on the cover page?

APPENDIX C

MINNEAPOLIS: INDEPENDENT LIVING ASSESSMENT PROFILE
(sample pages)

INDEPENDENT LIVING ASSESSMENT PROFILE

Minneapolis Community Development Agency

KEY

LEVEL I - Independent

LEVEL II - Independent with Supportive Services

LEVEL III - Alternative Living Situation Required

■ Not Applicable

DATE	BASIC LIVING FUNCTIONS	LEVEL I	LEVEL II	LEVEL III	COMMENTS
	Meal Preparation - Diet				
	Housekeeping				
	Mobility				
	Toilet				
	Medications				
	Time, Place, Person				
	Planning & Decision Making				
	Mental Health				
	Chemical Use/Abuse				
	Safety Precautions				

SIC LIVING FUNCTIONS #1-10 NDARY LIVING FUNCTIONS #11-20	LEVEL I INDEPENDENT	LEVEL II INDEPENDENT WITH SUPPORTIVE SERVICES	LEVEL III ALTERNATIVE LIVING SITUATION
Meal Preparation - Diet	Able to prepare meals independently, eats without assistance	Requires health aid homemaker, family or friends to prepare adequate meals. Assistance is available and accepted.	Requires assistanc but refuses it. D pendable assistanc is not available.

FSTIONS:

Do you prepare your own meals?

How often?

Does anyone else ever prepare meals for you? If so, who and how frequently?

Never
Occasionally
Regularly

If you do not prepare all of your own meals, what resources do you use - such as meals on wheels - congregate meals.

Do you feel that you handle your meal preparation adequately?

Describe a typical meal that you prepare for yourself.

Do you feel that you need assistance preparing meals from time to time? If so, how often?

Do you feel that you receive adequate nutrition?

Are you losing, gaining, or maintaining your weight?

Do you feel that you need to have someone regularly prepare meals for you because you cannot do it yourself?

MMENTS:

APPENDIX D

AKRON: PISCES ASSESSMENT PROCESS
(sample pages)

FUNCTIONING STATUS

Name _____ Date _____

	Circle ONE number to indicate how the individual performs each task	BY SELF	WITH HELP			DOES NOT DO	DESCRIBE SITUATION	UNMET NEEDS
			MECHANICAL AID ONLY	HUMAN HELP ONLY	MECHANICAL AID & HUMAN HELP			Yes
*ACTIVITIES OF DAILY LIVING	BATHING	1	2	3	4	5		
	GROOMING	1	2	3	4	5		
	DRESSING	1	2	3	4	5		
	EATING / FEEDING	1	2	3	4	5		
	TRANSFERRING	1	2	3	4	5		
	TOILETING	1	2	3	4	5		
	BOWEL CONTROL	1	2	3	4	5		
	BLADDER CONTROL	1	2	3	4	5		
INSTRUMENTAL ACTIVITIES OF DAILY LIVING	TELEPHONE	1	2	3	4	5		
	ABILITY TO TRAVEL	1	2	3	4	5		
	TRANSPORTATION	1	2	3	4	5		
	SHOPPING	1	2	3	4	5		
	MEAL PREPARATION (Hot / Cold)	1	2	3	4	5		
	HOUSEKEEPING	1	2	3	4	5		
	LAUNDRY	1	2	3	4	5		
	HEAVY CHORES	1	2	3	4	5		
	MANAGING LEGAL / FINANCIAL AFFAIRS	1	2	3	4	5		
	YARDWORK / MAINTENANCE	1	2	3	4	5		
	MEDICATIONS	1	2	3	4	5		
*MOBILITY	WALKING	1	2	3	4	5		
	WHEELING	1	2	3	4	5		
	STAIRCLIMBING	1	2	3	4	5		

FREQUENCY OF AVAILABLE HELP WITH FUNCTIONING

P = PRN (as needed)
D = Daily
W = Weekly
2-6 = Times Weekly
S = Semimonthly
M = Monthly
O = Other
U = Unknown

NAME AND RELATIONSHIP AND / OR AGENCY	BATHING	GROOMING	DRESSING	EATING / FEEDING	TRANSFERRING	TOILETING	TRANSPORTATION	SHOPPING	MEAL PREPARATION	HOUSEKEEPING	LAUNDRY	LEGAL / FINANCIAL	MEDICATIONS	LIVING SPACE	OTHER

DICAL STATUS

NAME _____ DATE _____

	NO IMPAIRMENT	DESCRIBE IMPAIRMENT	DESCRIBE COMPENSATION	DESCRIBE ADEQUACY OF COMPENSATION
HT				
ARING				
SPEECH				
NTITION				

FRACTURES / DISLOCATIONS ____ None
(Specify location / treatment / date)

JOINT MOTION ____ No Problems
(Specify limited motion)

RALYSIS / PARESIS ____ None
(Specify location)

MISSING LIMBS ____ None
(Specify)

CURRENT DIAGNOSES	PER MEDICAL RECORD	DATE OF ONSET	CURRENT DIAGNOSES	PER MEDICAL RECORD	DATE OF ONSET

PAST MEDICAL HISTORY			PAST MEDICAL HISTORY		

MILY HISTORY

LERGIES / KNOWN REACTIONS TO DRUGS

SPECIAL DIETS

ESCRIPTION MEDICATIONS

ame / Action	Dosage / Frequency	Start / End Dates

OVER-THE-COUNTER MEDICATIONS

Name / Action	Dosage / Frequency

MEDICATION ADMINISTRATION
___ Self-Administered
___ Monitored by _____

DATE OF LAST VISIT TO PHYSICIAN

DATE/REASON/PLACE OF LAST HOSPITALIZATION

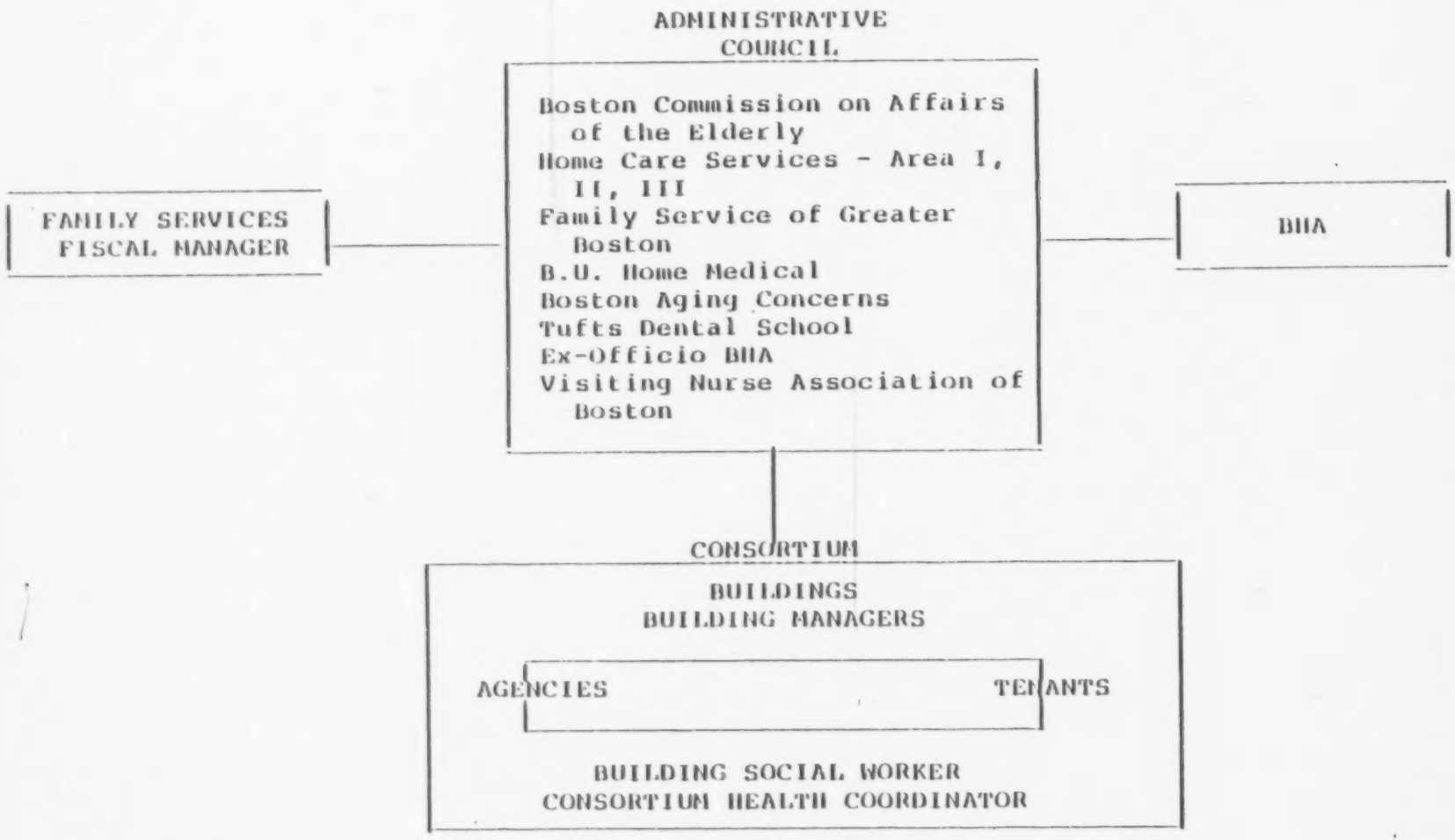
TOBACCO USE ___ Yes ___ No
Specify frequency

ALCOHOL USE ___ Yes ___ No
Specify frequency

APPENDIX E

BOSTON: CONSORTIUM ORGANIZATIONAL CHART

CONSORTIUM FOR HEALTH AND SOCIAL SERVICES
IN THE BHA ELDERLY DEVELOPMENTS



APPENDIX F

MOBILE: HOME VISIT INTERVIEW OUTLINE

NAME_____ DATE_____

ADDRESS_____ WORKER_____

TELEPHONE_____

OUTLINE OF POINTS TO BE CONSIDERED ON HOME VISITS FOR APPLICANTS - FRANK W. BOYKIN TOWER

1. Able to function, manage and maintain their own household.

2. Housekeeping habits; observe whether or not the house is in good order. Are the beds made, the kitchen clean, etc.

3. Check rent-paying record; their ability to manage funds.

4. Ascertain whether or not they will be able to make the adjustment to the high ri

5. Note the extent of friendships, church relationships, etc. as against whether or not they are withdrawn and have no friends.

6. Get name of sponsor and alternate sponsor.

7. Note any talents they may have or hobbies, etc.

8. Observe for mental alertness or conditions; bad personal habits (smoking, drinking).

9. No children in the building; no one to live there except senior citizens.

RECOMMENDATION:

APPENDIX G

MOBILE: PROCEDURES FOR TRANSITIONALYZING ELDERLY WHO BECOME DEPENDENT

MOBILE HOUSING BOARD
COMMUNITY SERVICES

PROCEDURES FOR TRANSITIONALIZING ELDERLY WHO BECOME DEPENDENT

The Mobile Housing Board provides 4192 apartments in conventional public housing of which 48% or 1943 are elderly or handicapped individuals or families. A full range of typical supportive services are provided with a major program carried out by Senior Citizens Services of Mobile County. The agency is housed at Central Plaza Towers with facilities and utilities supplied by the Mobile Housing Board. Community Services also provides transitional services through the Board's Section 8 Housing Program for elderly residents.

The elderly and handicapped are initially housed based on their ability to live and function independently. At application, a sponsor and alternate sponsor is obtained. When there is question with respect to ability to live independently, Leasing & Occupancy refers the applicant to Community Services. At this time, a home visit is made and information obtained and explored as noted in Exhibit No. 1. The information is forwarded to L & O together with the recommendation.

RESOURCES

After housing, the applicant is acquainted with a full range of services available in the community. People who are active and outgoing that utilize their talents and hobbies tend to live longer and enjoy a higher quality of life. The Mobile Housing Board through discovering these talents and matching them with the resident's interests and abilities offers a new experience in retirement living through agencies that provide a full range of services from crafts to art, travel, ceramics, transportation, chapel, meals and so on largely through the Senior Citizens Services, Senior Companion Program of Mobile County and other community agencies such as Meals on Wheels and the Senior Activities for Independent Living (SAIL) Program of the South Alabama Regional Planning Commission.

STAGES OF LIFE

Various Stages of life present difficult adjustment periods. We resist change of life styles. There is tremendous adjustment and growth from childhood to latency; adolescence to adulthood and maturity. All of us at some point in life, if we live long enough, will become physically impaired and dependent. Chores such as the daily routine of house cleaning, dressing, and food preparation become extremely difficult to handle and gradually are neglected. In later years neighbors and friends drop away. Often there are no family or friends left. The Mobile Housing Board, an agency or church sometimes is the only resource the dependent elderly can turn to. Problems in getting new friends are compounded. These changes are recognized by the elderly person and causes withdrawal and denial. Sometimes family support is lost. Children move away to other parts of the country or become disinterested. Loss of friends, dependence on others for menial chores is a daily reminder of life slipping away. Having to go to a nursing home, foster home, or institution is recognized as the final stage.

To achieve the necessary transition to a more protective environment, the worker must have the cooperation of the tenant. To do this requires warmth,

understanding, compassion and firmness. This is achieved through making home visits, reviewing alternatives and options through discussion and providing the necessary community resources to help allieviate these feelings of rejection and loneliness.

I. INITIAL CONTACT: REFERRAL

Initial referral comes from one of several sources, such as, the project manager, neighbors, church or social agency. In some cases, the elderly person asks for help themselves. In any event, the Community Services Social Worker coordinates and clears with the project manager to obtain the track record of the tenant's past strengths and weaknesses and the current presenting problems. Information is then gathered from the following sources:

A) Sponsor
B) Family member
C) Physician
D) Homemaker; Visiting Nurse
E) Minister
F) Neighbor
G) Other Agencies

II. FIRST STEP

At this stage, we find the person is usually withdrawn and suffering from depression which is brought about by fear and relationship problems such as loss of a loved one or rejection. The social worker assists the person to overcome despondency by renewing a dormant interest or establishing new relationships. Many of these initial referrals are resolved by getting the person to participate in such things as the SAIL Program for socialization and a hot meal each day. Others find interest in crafts or friendly visits developed through church outreach. Many have a transportation problem or need help in getting to the doctor or clinic. We have found that many can continue for months with this minimum assistance.

III. SECOND STEP

For those who have become physically impaired and dependent the Mobile Housing Board is fortunate to have the Homemaker Service as a major resource. The homemaker provides companionship, cleaning services, prepares meals, and so on for a few hours each week. Currently, this program is serving 150 elderly residents who are partially dependent. Each of these families have been visited by the Community Services social worker and a plan of action developed. This social worker is responsible for developing an initial plan of action and is responsible for linkage of each case into the homemaker program.

The homemaker service is the first line of defense and provides a valuable alternative that enables residents to ward off that final stage of institutionalization. Through this program they can remain in their own homes in familiar surroundings. Practically all of our cases are resolved at this point. Many live out their years with the homemaker assistance. The majority of cases who become so dependent that the homemaker service finds that 24-hour care is needed, eventually must be placed in a foster home, nursing home or with family.

IV. STEPS TAKEN-DEPENDENT ELDERLY

The dependent tenant's needs may be identified from any one of the foregoing service agencies. A home visit is made. The plan of action is updated working with the manager, family, and the tenant based on the present needs. What we find at this time is that the elderly dependent falls in one of two categories: Cooperative or Non-Cooperative. Approximately 15 cases per year fall in the non-cooperative category. These cases require extensive consultation and work usually over a period of several months.

A. COOPERATIVE TENANT

1. Arrange temporary stay in hospital or nursing home or have family with tenant as needed.
2. Permanently move tenant to a nursing home, boarding home or with family members.
3. Report to Department of Pensions and Security social worker the need for foster care if indicated.
4. Many unwilling to go to alternative care (at first), because they insist they can live alone, later change their minds when they are faced with an actual dangerous situation such as a fall with no one there to help.

11. In crises cases such as suicide, call on Crisis Center-Mobile Mental Health Center.

B. NON-COOPERATIVE TENANT

1. Work with someone the tenant can relate to, i.e. physician or sponsor in hopes that with clear information they will agree to consider other alternatives suited to their needs.
* 2. Immediately report tenant to the Adult Protective Services of DPS.
3. Call on Legal Advocacy for the Elderly for legal assistance and for help in screening adequate 24-hour placement.
4. Consult with MHB attorney as necessary to gain assistance in handling the case especially if there is no family.
5. In cases where tenant is hospitalized, work with Social Services staff and physician to place in 24-hour care from the hospital if needed.
6. Corisult with DPS and prepare document to go to court either Probate or Circuit whichever is appropriate.
7. Send case summary letter to DPS attorney and others stating that in the opinion of the Mobile Housing Board the tenant is no longer able to care for himself and is in danger of harming himself or his neighbors and request alternate care be arranged . (See Exhibit No. 2)
8. Prepare witnesses for court working with the attorneys.
** 9. Consult with DPS to locate suitable alternate care for tenant so the court is aware that there is a place for the tenant to move to.
10. In the event the court rules in favor of the tenant, case monitoring is continued until the appropriate time to go back to court or that the tenant becomes so ill the doctor agrees to place him/her in a nursing home or institutio

The Mobile Housing Board is fortunate to have the homemaker service which enables many residents to live in their own homes without placement. This prevents a lot of difficulty for housing management. Most live out their lives before becoming totally dependent. For those who are transitionalized, a follow-up visit is often necessary. In practically all cases, the elderly dependent person is pleased once the transition is completed.

**DPS provides Protective Services as outlined in the code of Alabama §38-9-4.*

***Court will not remove tenant from his/her home unless there is pre-arranged alternate care.*

APPENDIX H

MOBILE: SENIOR CENTER CALENDAR

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
	1 9:30 AM EXERCISE CLASS/302 10:00 AM HOSTESS CLUB/300 10:00 AM CERAMICS CLASS 10:30 AM DANCE FOR FUN/302 12:00 NOON LUNCH 2:00 PM BRITTON'S CRAFTS 2:00 PM BEL AIR MALL 7:00 PM GOSPEL SING/302	2 10:00 AM SEWING CLASS 12:00 NOON LUNCH 12:30 PM HIRE OLDER WORKERS 1:00 PM CERAMICS CLASS 1:00 PM LIBRARY/300 2:00 PM CANASTA/BRIDGE 3:00 PM BIBLE STUDY/CHAPEL 3:30 PM AQUATIC EXERCISE CLASS	3 9:30 AM DEVOTIONAL/CHAPEL 10:00 AM NEEDLE PUNCH CLASS 12:00 NOON LUNCH 2:00 PM B I N G O 2/$1.00 4:00 PM MASS/CHAPEL	4 9:30 AM EXERCISE CLASS/302 10:00 AM CERAMICS CLASS 10:45 AM WINN DIXIE 12:00 NOON LUNCH 1:00 PM TUBE PAINTING 1:00 PM LIBRARY/300 3:30 PM AQUATIC EXERICSE 1:00 PM INCOME TAX ASSISTANCE
7 10:00 AM JOLLY SENIORS BAND 10:00 AM CROCHET/KNITTING CLASS 12:00 NOON LUNCH 1:00 PM LIBRARY/300 2:00 PM BUSY HANDS CRAFT CLASS 3:30 PM AQUATIC EXERCISE CLASS 7:00 PM BIBLE STUDY/CHAPEL	8 9:30 AM EXERCISE CLASS/302 10:00 AM CERAMICS CLASS 10:30 AM DANCE FOR FUN/302 12:00 NOON LUNCH 2:00 PM BRITTON'S CRAFTS 2:00 PM SPRINGDALE MALL 6:30 PM BIBLE STUDY/CHAPEL 7:00 PM GOSPEL SING/CHAPEL	9 10:00 AM SEWING CLASS 10:00 AM HEARING CLINIC 12:00 NOON LUNCH 12:30 PM HIRE OLDER WORKERS 1:00 PM CERAMICS CLASS 1:00 PM LIBRARY/300 2:00 PM CANASTA/BRIDGE 3:00 PM DENTAL HEALTH PROGRAM 3:00 PM BIBLE STUDY/CHAPEL	10 9:30 AM DEVOTIONAL/CHAPEL 10:00 AM NEEDLE PUNCH CLASS 12:00 NOON LUNCH 2:00 PM BIRTHDAY PARTY/DANCE music by JOLLY SENIORS BAND 4:00 PM MASS/CHAPEL	11 9:30 AM EXERCISE CLASS/302 10:00 AM CERAMICS CLASS 10:45 AM FOOD WORLD 12:00 NOON LUNCH 1:00 PM TUBE PAINTING 1:00 PM LIBRARY/300 3:30 PM AQUATIC EXERCISE 1:00 PM INCOME TAX ASSISTANCE
14 10:00 AM JOLLY SENIORS BAND 10:00 AM CROCHET/KNITTING CLASS 12:00 NOON LUNCH 1:00 PM LIBRARY/300 2:00 PM BUSY HANDS CRAFT CLASS 3:30 PM AQUATIC EXERCISE CLASS 7:00 PM BIBLE STUDY/CHAPEL	15 9:30 AM EXERCISE CLASS/302 10:00 AM CERAMICS CLASS 10:30 AM DANCE FOR FUN/302 12:00 NOON LUNCH 2:00 PM BRITTON'S CRAFTS 2:00 PM BEL AIR MALL 7:00 PM GOSPEL SING/CHAPEL	16 10:00 AM SEWING CLASS 12:00 NOON LUNCH 12:30 PM HIRE OLDER WORKERS 12:30 PM FOOD STAMPS 1:00 PM CERAMICS CLASS 1:00 PM LIBRARY/300 2:00 PM CANASTA/BRIDGE 3:00 PM BIBLE STUDY/CHAPEL	17 9:30 AM DEVOTIONAL/CHAPEL 12:00 NOON LUNCH 2:00 PM VOLUNTEER AWARDS PROGRAM/CROWNING OF SENIOR CITIZEN OF THE YEAR 4:00 PM MASS/CHAPEL	18 9:30 AM EXERCISE CLASS/302 10:00 AM CERAMICS CLASS 10:45 AM DELCHAMPS 12:00 NOON LUNCH 1:00 PM TUBE PAINTING 1:00 PM LIBRARY/300 3:30 PM AQUATIC EXERCISE
21 10:00 AM JOLLY SENIORS BAND 10:00 AM CROCHET/KNITTING CLASS 12:00 NOON LUNCH 1:00 PM LIBRARY/300 2:00 PM BUSY HANDS CRAFT CLASS 3:30 PM AQUATIC EXERCISE CLASS 7:00 PM BIBLE STUDY/CHAPEL BALLOON RELEASE	22 9:30 AM EXERCISE CLASS 10:00 AM CERAMICS CLASS 10:30 AM DANCE FOR FUN 12:00 NOON LUNCH 2:00 PM BRITTON'S CRAFTS 2:00 PM SPRINGDALE MALL 6:30 PM BIBLE STUDY/CHAPEL 7:00 PM GOSPEL SING/CHAPEL	23 10:00 AM SEWING CLASS 12:00 NOON LUNCH 12:30 PM HIRE OLDER WORKERS 1:00 PM CERAMICS CLASS 1:00 PM LIBRARY/300 2:00 PM CANASTA/BRIDGE 3:00 PM BIBLE STUDY/CHAPEL 3:30 PM AQUATIC EXERCISE CLASS	24 8:00 AM NEW ORLEANS TRIP 9:30 AM DEVOTIONAL/CHAPEL 10:00 AM NEEDLE PUNCH CLASS 12:00 NOON LUNCH 4:00 PM MASS/CHAPEL	25 9:00 AM NEWSLETTER/300 9:30 AM EXERCISE CLASS 10:00 AM CERAMICS CLASS 10:45 AM WINN DIXIE 12:00 NOON LUNCH 1:00 PM TUBE PAINTING 1:00 PM LIBRARY 3:00 PM AQUATIC EXERCISE
28 9:00 AM BLOOD PRESSURE CLINIC 10:00 AM JOLLY SENIORS BAND 10:00 AM CROCHET/KNITTING CLASS 12:00 NOON LUNCH [redacted]	29 9:30 AM EXERCISE CLASS 10:00 AM CERAMICS CLASS 10:30 AM DANCE FOR FUN/302 12:00 NOON LUNCH [redacted]	30 10:00 AM SEWING CLASS 12:00 NOON LUNCH 12:30 PM HIRE OLDER WORKERS 1:00 PM CERAMICS CLASS [redacted]	SENIOR CITIZENS SERVICES, INC. CALENDAR OF EVENTS [redacted]	

APPENDIX I

ST. PAUL: INDEPENDENT LIVING SKILLS
(sample pages)

INDEPENDENT LIVING SKILLS

Critical Factors

CLASSIFICATION I INDEPENDENT	CLASSIFICATION II INDEPENDENT WITH SUPPORTIVE SERVICES	CLASSIFICATION III ALTERNATIVE LIVING SITUATION REQUIRED
1) Able to prepare adequate meals independently. Eats without assistance.	Requires health aide/ homemaker, family or friends to prepare adequate meals on periodic or short term basis. Eats with minor assistance and may be untidy.	Requires extensive regular assistance with all meals or refuses to prepare or eat adequate meals. Totally dependent on health aide/ homemaker/family or friends for preparing of adequate meals. Refuses assistance or assistance is not available.
2) Does housekeeping alone or with occasional help with heavy work.	Performs light housekeeping tasks but cannot maintain acceptable level of cleanliness without chore service/homemaker. Assistance is available and accepted.	Needs extensive regular help with all housekeeping tasks. Does not participate in any housekeeping tasks or refuses assistance in maintaining acceptable level of cleanliness or assistance is not available.
3) Is mobile without any aids, can walk 6 to 8 blocks and climb stairs without assistance.	Is mobile with mechanical aids (wheelchair, cane, crutches, walker, braces) and/or occasional available assistance. Able to go in and out of wheelchair without assistance.	Requires extensive regular assistance to carry out routine living functions in and out of wheelchair, toilet, dressing. Refuses assistance or assist is not available.
4) Toilet - Cares for self at toilet completely. No incontinence.	Needs reminders about or minor & occasional assistance with toilet-personal care. May soil or wet while asleep.	Soils or wets while awake or has no control over bladder or bowels.
5) Medications - Is responsible for taking medications in correct dosages at correct times without assistance.	At times confused by medications and requires periodic supervision of dosages. Supervision available and accepted.	Requires daily or excessive supervision of medications for more than short period of time. Refuses supervision or supervision is not available.

INDEPENDENT LIVING SKILLS

CLASSIFICATION I INDEPENDENT	CLASSIFICATION II INDEPENDENT WITH SUPPORTIVE SERVICES	CLASSIFICATION III ALTERNATIVE LIVING SITUATION REQUIRED
11) Obtains own groceries and other items needed for daily living.	Obtains own food and other necessary items with some assistance from others. Assistance is available.	Cannot or will not obtain food and other necessary items. Refuses assistance or assistance is not available.
12) Manages financial matters independently. (Budgets, writes and cashes checks, pays rent & bills, goes to bank, collects & keeps track of income.)	Manages some day-to-day purchases but needs help with banking & major purchases. May have or need conservator.	Incapable of handling financial matters. Has or needs guardian. Refuses assistance or assistance is not available.
13) Travels independently on public transportation or drives own car or arranges own travel via taxi.	Travels on public transportation when assisted by others or travels in taxi or automobile with assistance of others. Occasionally requires others to make transportation arrangements for them. Assistance is available.	Requires extensive assistance with transportation or help in obtaining transportation for medical/dental appointments. Does not or will not travel or adequate transportation is not available.
14) Bathing: Bathes self - (Tub-shower-sponge bath) without help.	Bathes self with help in getting in and out of tub, shower, or washes face & hands only but cannot bathe rest of body. Accepts available assistance of family, friends or health aide/homemaker to bathe rest of body.	Cannot or will not wash self. Refuses assistance or assistance is not available.
15) Dressing: Dresses, undresses & selects clothes from own wardrobe with no or very minor assistance.	Needs moderate assistance on dressing, undressing & selection of clothes - assistance is available and accepted.	Needs major assistance with dressing and/or assistance with dressing is not available.

Contributory factors

APPENDIX J

ST. PAUL: PROCEDURES REGARDING TENANT SPONSOR STATEMENTS

PUBLIC HOUSING AGENCY OF THE CITY OF SAINT PAUL
380 Bremer Building, 419 North Robert Street, Saint Paul, Minnesota 55101, phone (612) 298-5668

DATE February 3, 1986

TO Housing Managers:Assistant Managers:Human Services Coordinators:
Assistant Rental Officer:Public Housing Rental Technicians

FROM Erik-Paul Sallmen, Rental Officer and
Virginia Jellison, Principal Manager

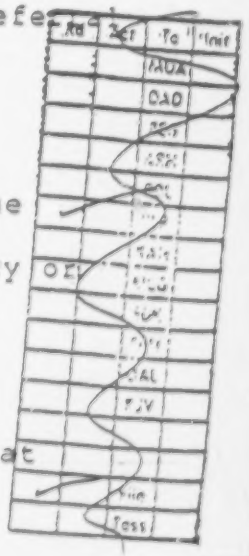
SUBJECT Standard Operating Procedure Regarding Tenant Sponsor Statements

MEMO

Set forth below are the specific responsibilities of Human Services Coordinators, Rental Office staff, Housing Managers and Assistant Managers, respectively, regarding the preparation of Tenant Sponsor Statements. Please review this procedure thoroughly and file for future reference.

A. HUMAN SERVICES COORDINATORS' RESPONSIBILITIES:

1. As appropriate, state clearly in Rental Office Refe[illegible] forms that a Sponsor Statement is recommended.



2. State the full name of the person who is to be the Sponsor and, if applicable, the name of the agency or organization the Sponsor represents.

3. State specifically, the items or service needs that must be covered in the Sponsor Statement.

4. State whether or not you have discussed the possibility of a need for a Sponsors Statement with the Sponsor and the applicant. Indicate whether or not they are agreeable.

B. RENTAL OFFICE STAFF'S RESPONSIBILITIES (in the event the decision is made to admit the applicant):

1. Review Coordinator's recommendations concerning Sponsor Statements and contact the Coordinators in the event clarifications are necessary.

2. Draft the Sponsor Statements including the Sponsor's name (and agency or organization as applicable), the applicant's name, hi-rise and apartment number and the specific items or service needs that must be addressed by the Sponsor.

3. Contact the Sponsor and applicant and review the specifics of the Statement with them. Tell them that the Statement will have to be signed at the same time the Lease is signed.

4. Include the completed (but unsigned) Sponsor Statements in applicant files that are routed to Management Offices.

C. MANAGERS' RESPONSIBILITIES:

1. Review the Sponsor Statements and seek any necessary clarifications from either the Human Services Coordinator or the Rental Office.

2. Contact the applicant and the Sponsor to arrange an appointment to sign the Statement and the Lease.

3. Make sure that both the applicant and the Sponsor understand their respective responsibilities under the Statement.

4. Insert the Statement in the tenant's file on top of documents on LEFT hand side.

5. Provide copies of signed Statement to Human Services Coordinator, Sponsor and tenant.

6. Review and update Sponsor Statements as the need arises.

APPENDIX K

HIGH POINT: HOME VISIT OUTLINE

Date _____

HOME VISIT

I. IDENTIFYING INFORMATION

Name _____ Age _____ Birthdate _____

A. ___ Lives Alone
___ Lives w/Spouse
___ Lives w/Relative
___ Lives w/Friend

B. ___ Apartment
___ Boarding Room
___ House
___ Nursing Home

C. Frailties

__Glaucoma
__Ambulation
__Diabetes
__Hypertension
__Poor Vision
__Heart Problem
__Arthritis
__Emphysema
__Breathing
__Other _____

__Kidney/Liver
__Nerves
__ALCOHOLISM
__Deafness
__Mental Retardation
__Cancer
__Memory/Confusion
__Stroke
__Balance

II. NEEDS ASSESSMENT - Activities of Daily Living

(S-Self F-Family A-Agency O-Other U-Undone)

		Comments
Housekeeping/Laundry		
Meal Preparation		#meals
Shopping/Bill Paying		
Bathing/Dressing		
Toileting		
Medications		
Transportation		

General Attitude: _____

Activity: _____

Orientation: ___Person ___Place ___Time

Memory: ___Remote ___Recent ___New Learning

EMERGENCY INFORMATION

A. Name _____ Social Security # _____

Apartment # _____ Phone # _____ Date of Birth _____

Church Affiliation _____ Funeral Home _____

B. Medical Doctor _____ Phone # _____

Frequency of Visits _____ Other Doctors _____

Medicare # _____ Medicaid # _____

Other Health Ins. ____ Company _____ Policy # _____

Are you allergic to any drugs ____ List _____

Diagnosis	Medication	Prescribed Frequency

C. Social Worker _____ Choreworker _____

In case of emergency, whom should we contact?

1. _____ Name

_____ Address

_____ Phone

_____ Relationship

2. _____ Name

_____ Address

_____ Phone

_____ Relationship

APPENDIX L

HIGH POINT: CONGREGATE HOUSING ASSESSMENT
(sample pages)

Date _____

Name _____ Date Became Participant _____

Apartment # _____ Date of Birth _____ Age _____

Family Contact _____ Address _____ Phone _____

Social Worker _____ Chore Worker _____

Managing Apartment Living	Self	Family Hired Help	Friend Chore Wker	Does Undone	Comments
Cooking					
Laundry					
Grocery Shopping					
Paying Bills					
Reading Mail					
Writing Letters					
Window Washing					
Take Out Trash					
Vaccuming					
Changing Beds					
Making Beds					
Dusting					
Mopping					
Clean Appliances					
Scour Bathrooms					

SERVICE/SUPPORT PLAN

Looking Your Best	Self	Family Hired Help	Friend Chore Worker	Does Undone	Comments
Taking A Bath					
Washing Hair					
Shaving					
Dressing					
Care for Nails					
Care for Dentures					
Other					

SERVICE/SUPPORT PLAN

Getting Out	Check	Comments
I drive my own car		
I get someone to drive my car		
I take the public bus		
I depend on family/friends		
I call Dial-a-Ride		
Dial-a-Lift		
Cab		
Council on Aging		
I like to walk		

SERVICE/SUPPORT PLAN

Keeping Busy	Check	Comments
Visits friends in the building		
Attends club meetings		
Attends church/Sunday School		
Visits Family		
Family Visits		
Television/Radio		
Reading		
Arts and Crafts		
Puzzles		
Other		

SERVICE/SUPPORT PLAN

What's on Your Mind	Check	Comments
Frustrated by declining strength		
Feels isolated and lonely		
Sometimes forgets and feels confused		
Anxious about health		
Worried about finances		
Cheerful despite circumstances		

General Attitude:

Time Orientation:

Sleeping Habits:

SERVICE/SUPPORT PLAN

Family Support	Check	Comments
They want me to call them anytime I need them		
I enjoy calls from my family		
My family only calls when they need something		
They always remember my birthday		
They write to let me know what's happening		
They want to do too much for me		
I couldn't pay my bills without their help		

Other

****

SERVICE/SUPPORT PLAN

FEELING GOOD

I. Physicians

Medical Doctor _____ Phone _____

Dentist _____ Phone _____

Ophthalmologist _____ Phone _____

Other _____ Phone _____

II. Doctor's Visits

Frequency of Visits _____

Who arranges doctor's appt.? _____

Do you need and escort to the doctor? _____

Medicare # _____ Medicaid # _____

III. Medications

Diagnosis	Medication	Prescribed Frequency	Takes as Prescribed

Drugstore_____ Phone_____ Pick-up__Delivery__

Comments_____

IV. Disabilities

Disability	Level of Disability	Comments
Ambulatory		wheelchair__walker__cane__
Visual		glasses__
Auditory		hearing aid__
Mental		
Other		

V. Special Diet_____

****

SERVICE/SUPPORT PLAN